Chardon Community Day Care Center

Providing caring, skilled and affordable service since 1970

ENROLLMENT PACKET

12797 Mayfield Rd. Chardon, OH 44024 (440) 286-4135

www.chardondaycare.org ccdcc@live.com

www.facebook.com/chardondaycare

A Program of

Chardon Community Day Care Center

Dear Parents and Guardians,

Thank for your interest in Chardon Community Day Care Center! Our non-profit daycare center has been caring for and educating children since 1970. We look forward to providing a safe environment for your child through quality care, educational development and promotion of healthy habits. Our staff will provide developmental enrichment through physical, emotional and educational activities. Our center offers breakfast, lunch and two snacks each day to help busy families.

Chardon Community Day Care Center is proud to have achieved 1 Star certification in the *Step Up to Quality* Program – the only day care in Chardon to have obtained this rating. A star rating proves that our center operates above and beyond Ohio's minimum licensing requirements and receives regular visits from State inspectors.

We realize leaving your child for the day can become emotional for both parents and children. Please stop in anytime to visit with your child or inspect our center.

To enroll your child please complete the forms in this packet and pay the $50 registration fee (per family). You can mail or drop off forms and payment, whichever you prefer. We accept cash, checks, money orders and credit cards.

You can call us Monday through Friday from 6:00 a.m. to 6:30 p.m. with any questions or concerns. We look forward to getting to know your family and meeting your child's needs.

Sincerely,

Robin Ulmer
Center Director

12797 Mayfield Rd. Chardon, OH 44024 (440) 286-4135
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A Program of

"In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

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step up to quality

FY 2012 Enrollment Packet Table Of Contents

PAGE NUMBER (red ink)	TOPIC	INSTRUCTIONS
1 – 4	Child Enrollment and Health Information	Complete and return these 2 pages
5 – 6	Child Medical Statement	Complete and return this page
7 – 8	Pick Up Authorization List	Complete and return this page
9 - 10	Building for the Future	Keep this page
11 - 12	Infant Meals – Parent Preference	Complete and return this page if you are enrolling an infant under 1 year of age
13	Household Letter	Keep this page
14	And Justice for All Poster	Keep this page
15 - 16	Child and Adult Care Food Program – Income Eligibility Application for Free and Reduced Price Meals FY2011 - 2012	Complete this page only if you ARE income eligible according to guidelines on page 13
17	Child and Adult Care Food Program Enrollment Form A	Complete and return this page regardless of your household income but **ONLY** if your child is school-age
18	Child and Adult Care Food Program Enrollment Form C	Complete and return this page regardless of your household income but **ONLY** if your child is school-age
19 – 20	USDA Food Program Waiver	Complete this form if you are NOT income eligible according to guidelines on page 13
21	WIC Clinic Locations (Geauga County)	Keep this page
22	Center Parent Information	Keep this page
23	Fees	Keep this page

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Ohio Department of Job and Family Services

CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE CENTERS AND TYPE A HOMES

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name	Date of Birth	First Day at Center
Home Address		City
State	Zip Code	Home Telephone Number

Parent/Guardian Name	Relationship to Child
Home Address	

City	State	Zip
Home Telephone Number	Cell Phone	
Work/School Telephone Number	Work/School Name	
Work/School Address		City

Please indicate if this name should be included on a parent roster ☐ Yes ☐ No
If you answered yes, please indicate which number above to list on the roster ☐ Work number ☐ Cell number ☐ Home number

Where can you be reached while your child is in this program?

Parent/Guardian Name	Relationship to Child
Home Address	

City	State	Zip
Home Telephone Number	Cell Phone	
Work/School Telephone Number	Work/School Name	
Work/School Address		City

Please indicate if this name should be included on a parent roster ☐ Yes ☐ No
If you answered yes, please indicate which number above to list on the roster ☐ work number ☐ cell number ☐ home number

Where can you be reached while your child is in this program?

Emergency Contacts: Parents **cannot be listed** as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness **if you cannot be reached.** Any person listed should be able to assist in contacting you and at least one person listed must be within one hour of the center/home and able to take responsibility for the child in case you cannot be contacted.

Name		Name	
City	State	City	State
Telephone Number	Relationship to Child	Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached (if applicable)		Other numbers where emergency contact can be reached (if applicable)	

Name of Physician or Clinic/Hospital		
Street Address		
City	State	Telephone Number

Child's Name

Allergies, Special Health or Medical Conditions, and Food Supplements

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or type A home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

☐ No

☐ Yes - check all that apply ☐ Food ☐ Medication ☐ Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor child for symptoms, take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Does your child have a special health or medical condition? (*check one*)

☐ No

☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, monitor your child for symptoms or administer medication during child care hours? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication, food supplement, or medical food need to be administered at the child care center/type A home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.

☐ N/A - program does not administer any medications.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

☐ No

☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

☐ No

☐ Yes - written instructions from the child's health care provider must be on the JFS 01217 "Request for Administration of Medication."

☐ N/A - child does not attend a full time program.

Child's Name

List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff **or medical personnel** in an emergency situation**.**
List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page.

Diapering Statement

Is your child toilet trained? ☐ Yes (If yes, skip to Emergency Transportation Authorization section) ☐ No

The program's policy is to check diapers every _____ hours. Please indicate if you want your child's diaper checked according to the center/type A home's policy or another:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

Give *Permission* to Transport		**OR**	***Do Not Give Permission* to Transport**	
Center or Type A Home Name		**Do not sign both**	Center or Type A Home Name	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.			**does not have permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:	
Parent's Signature	Date		Parent's Signature	Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the center's or type A home's policies and procedures/handbook.

Parent/Guardian Signature	Date

Signatures

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care. The administrator shall have the parent/guardian review and initial the form when any changes/updates are made and at least annually. The parent/guardian and the administrator or designee shall initial and date the form to indicate the date reviewed.

Parent/Guardian Signature(s)			Date
Administrator/Designee Signature			Date
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note: This is a prescribed form which must be used by centers and type A homes to meet the requirements of rules 5101:2-12-37 and 5101:2-13-37. This form must be on file at the center or type A home on or before the child's first day of attendance and thereafter while the child is enrolled.

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Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT

For Child Care Centers and Type A Family Child Care Homes

Child's Name *(print or type)*	Date of Birth

This is to certify all of the following:

- I have examined this child and found that he or she is in suitable condition for participation in group care.
- The child has had the age appropriate immunizations recommended by the Ohio Department of Health.
- My office has entered the child's immunizations record below or attached a printed record of the immunizations or found that this child should be exempt from immunizations for the following reasons: _____

List any limitations or health conditions for this child (including allergies, daily medication, dietary restrictions) _____

Recommended Immunizations (*enter month, day, and year*)

Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Diphtheria, Tetanus, Pertussis (DTaP)					
Hepatitis B (Hep B)					
Haemophilus Influenza type b (HIB)					
Measles, Mumps, Rubella (MMR)					
Inactivated Polio					
Varicella (chicken pox)					
Influenza					
Pneumococcal Conjugate (PCV)					
Rotavirus					
Hepatitis A					
Other					

The immunizations above are recommended by the Centers for Disease Control and Prevention and the Ohio Department of Health.

Recommended Assessments/Screenings:

Vision: ☐ Yes ☐ No Date: _____
Dental: ☐ Yes ☐ No Date: _____
BMI: ☐ Yes ☐ No Date: _____

Hearing: ☐ Yes ☐ No Date: _____
Lead: ☐ Yes ☐ No Date: _____
Other: _____

Signature of examining Physician/Physician's Assistant/Advanced Practice Nurse	Date of Examination

Ohio Administrative Code rules 5101:2-12-37 and 5101-2-13-37 require that this examination be given no more than twelve months prior to the date of admission to the child care center or type A home.

Name of Physician /Physician's Assistant/Advanced Practice Nurse	Telephone Number
Street Address	
City, State and Zip Code	

This is a sample form used to meet the requirements of rules 5101:2-12-37 and 5101:2-13-37 of the Administrative Code.

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CHARDON COMMUNITY DAY CARE CENTER

PICK UP AUTHORIZATION LIST

Please list the people who have your permission to pick up your child(ren).

Child's Name: ____

Last First

1. **Name: ___________________________________** Phone: _____________________

   Relationship to Child: ________________________ Phone 2: _____________________

2. **Name: ___________________________________** Phone: _____________________

   Relationship to Child: ________________________ Phone 2: _____________________

3. **Name: ___________________________________** Phone: _____________________

   Relationship to Child: ________________________ Phone 2: _____________________

4. **Name: ___________________________________** Phone: _____________________

   Relationship to Child: ________________________ Phone 2: _____________________

5. **Name: ___________________________________** Phone: _____________________

   Relationship to Child: ________________________ Phone 2: _____________________

6. **Name: ___________________________________** Phone: _____________________

   Relationship to Child: ________________________ Phone 2: _____________________

Parent Name (print): ____

Last First

Parent Signature: _____________________________________ **Date:** ______________

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Building For the Future

This day care facility participates in the Child and Adult Care Food Program (CACFP), a Federal program that provides healthy meals and snacks to children receiving day care.

Each day more than 2.6 million children participate in CACFP at child care homes and centers across the country. Providers are reimbursed for serving nutritious meals which meet USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

Meals CACFP homes and centers follow meal requirements established by USDA.

Breakfast	Lunch or Supper	Snacks (Two of the four groups:)
Milk Fruit or Vegetable Grains or Bread	Milk Meat or meat alternate Grains or bread Two different servings of fruits or vegetables	Milk Meat or meat alternate Grains or bread Fruit or vegetable

Participating Facilities Many different homes and centers operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- **Child Care Centers**: Licensed or approved public or private nonprofit child care Centers, Head Start programs, and some for-profit centers.
- **Family Child Care Homes**: Licensed or approved private homes.
- **After School Care Programs**: Centers in low-income areas provide free snacks to School-age children and youth.
- **Emergency Shelters**: Programs providing meals to homeless children.

Eligibility State agencies reimburse facilities that offer non-residential day care to the following children:

- Children age 12 and under,
- Migrant children age 15 and younger, and
- Youths through 18 in emergency shelters and after school care programs in needy areas.

Contact Information If you have questions about CACFP, please contact one of the following:

Sponsoring Organization/Center

Chardon Community Day Care Center
12797 Mayfield Rd.
Chardon, OH 44024
(440) 286-4135

Ohio Department of Education

CACFP Consultant
25 S. Front Street, MS 303
Columbus, OH 43215-4183
614-466-2945

Nondiscrimination). In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

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INFANT MEALS – PARENT PREFERENCE

TO: **Parents and Guardians of infants under one year of age**

FROM: **Center or Provider:** **Chardon Community Day Care Center**

TOPIC: **Who will provide food for your infant's meals**

Due to participation on the Child and Adult Care Food Program (CACFP), all children enrolled at this child care center or family child care (FCC) home receive meals free of charge. The CACFP is a child nutrition program of the United States Department of Agriculture. Child care centers and family child care homes are reimbursed a meal rate to help with the cost of serving nutritious meals to enrolled children. These centers and FCC homes can be reimbursed daily for up to two meals and one snack served to each enrolled child, including infants. Emergency Shelters can be reimbursed for up to three meals. The meals must meet CACFP meal pattern requirements for children and infants.

To meet CACFP requirements, the center or FCC home is required to **offer** formula and other required infant food to all enrolled infants. The iron fortified infant formula we will provide for infants until they turn one year of age is:

Parent's Choice™ brand

A parent or guardian may decline the formula offered by the center or home and supply the infant's formula themselves. However, when an infant turns one year of age, the center or FCC home will begin to provide milk and the other required food items to meet the meal pattern requirements for toddler age children.

To assist us in your infant formula and food preferences, please complete the questions below by checking one item each in the formula and solid food section.

PLEASE CHECK YOUR PREFERENCES:

Formula or Breast Milk: (check one)

- ☐ I want the center or FCC home to provide formula for my infant.
- ☐ I will bring iron fortified infant formula for my infant
- ☐ I will bring expressed breast milk for my infant
- ☐ I will come to the center or FCC home to breast feed my infant

Solid Food: (check one)

- ☐ I want the center or FCC home to provide solid food for my infant when he/she is developmentally ready for it
- ☐ I will bring solid food for my infant when he/she is developmentally ready for it

Infant's Name:____**Birthdate:**____________________

Parent/Guardian
Signature:____**Date:**______________________

***Note: If your feeding preferences change, the center or provider will ask you to complete a new form.**

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington D.C. 20250-9410or call (202) 720-5964 (voice or TDD). USDA is an equal opportunity provider and employer.

Revised 7/30/03

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HOUSEHOLD LETTER - Dear Parent or Guardian:

Please help us comply with the requirements of the United States Department of Agriculture's Child and Adult Care Food Program (CACFP) administered through the Ohio Department of Education by completing the attached Income Eligibility Application for free and reduced price meals. All information will be treated with strict confidentiality. The CACFP provides reimbursement to the child care center for healthy meals and snacks served to children enrolled in child care. The completion of the Income Eligibility Application is OPTIONAL. Complete the application on the reverse side using the instructions below for your type of household. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center. Households with incomes less than or equal to the reduced price values listed on the chart at the bottom of this page are eligible for free meal benefits**.** An application must contain complete information to be considered for free or reduced price meals. Households are no longer required to report changes regarding the increase or decrease of income or household size or when the household is no longer certified eligible for Food Assistance or Ohio Works First (OWF). Once properly approved for free or reduced price benefits, a household will remain eligible for these benefits for a period not to exceed 12 months. During periods of unemployment, your child(ren) is eligible for meal reimbursement provided the loss of income during this time causes the family to be within eligibility standards for meals. In operation of the CACFP, no person will be discriminated against because of race, color, national origin, sex, age or disability §226.23(e)(2)(iv). If you have questions regarding the completion of this application, contact the child care center.

PART 1 – CHILD INFORMATION: ALL HOUSEHOLDS COMPLETE THIS PART

- Print the name of the child(ren) enrolled at the child care center. All children (including foster children) can be listed on the same application.
- List the enrolled child's age and birth date.
- Check box indicating if the child is a foster child. Foster children that are under the legal responsibility of the foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income.

PART 2 – HOUSEHOLDS RECEIVING FOOD ASSISTANCES OR OWF: COMPLETE THIS PART AND PART 4 – If a child is a member of a Food Assistance or OWF household, the child is automatically eligible to receive free CACFP meal benefits subject to application completion.

- Circle the type of benefit received (food assistance or OWF).
- List a current Food Assistance or OWF case number for each child. This will be a 10 or 12-digit number. Do not list a swipe card number.

SKIP PART 3 – Do not list names of household members or income if you listed a valid Food Assistance or OWF case number for each child in Part 2.

PART 3 – TOTAL HOUSEHOLD SIZE, GROSS INCOME & HOW OFTEN RECEIVED: ALL OTHER HOUSEHOLDS COMPLETE THIS PART & PART 4.

a) Write the names of all household members including yourself and the child(ren) that attends the child care center, whether they receive income or not. A household is defined as a group of related or unrelated individuals who are living as one economic unit that share housing and/or significant income and expenses of its members. This might include grandparents, other relatives, or friends who live with you. Attach another piece of paper if you need more space to list all household members.

b) Check the box for any person listed as a household member (including children) that has no income.

c) For each household member, list each type of income received during the last month and list how often the money was received.

1) *Earnings from work before deductions*: Write the amount of total gross income each household member received the last month, before taxes/deductions or anything else is taken out (not the take-home pay) and how often it was received (weekly, every other week, twice a month, monthly). Income is any money received on a recurring basis, including gross earned income. Households are not required to include payments received for a foster child as income. If any amount during the previous month was more or less than usual, write that person's usual monthly income. If you normally get overtime, include it, but not if you only get it sometimes. If you are in the military and 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. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

2) *List the amount each person got the last month from welfare, child support or alimony and list how often the money was received.*

3) *List the amount each person got the last month from pensions, retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits or disability benefits and list how often the money was received.*

4) *List all other income sources*. Examples include: Worker's Compensation, strike benefits, unemployment compensation, regular contributions from people who do not live in your household, cash withdrawn from savings, interest/dividends, income from estates/trusts/investments, net royalties/annuities or any other income. For only the self-employed, report income after expenses (net income) in column 1 under earnings from work. For your business, farm or rental property report income in column 4. Do not include food assistance payments.

PART 4 – SIGNATURE AND LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: ALL HOUSEHOLDS COMPLETE THIS PART

a) All applications must have the signature of an adult household member.

b) The adult signing the application must also date the form.

c) Only an application that lists income in Part 3 must have the last 4 digits of the social security number of the adult who signs. If the adult does not have a social security number, check the box "I do not have a Social Security Number." If you listed a Food Assistance or OWF number for each child or if you are applying for a foster child, the last 4 digits of the social security number are not required.

PART 5 – RACIAL/ETHNIC IDENTITY – OPTIONAL

You are not required to answer this part in order for the application to be considered complete. This information is collected to make sure that everyone is treated fairly and will be kept confidential. No child will be discriminated against because of race, color, national origin, gender, age or disability.

NON-DISCRIMINATION STATEMENT: This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication,1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

REDUCED INCOME ELIGIBILITY GUIDELINES – 185%
Guidelines to be effective from July 1, 2011 through June 30, 2012
Households with incomes less than or equal to the reduced price values below are eligible for free or reduced-price meal benefits.

HOUSEHOLD SIZE	YEAR	MONTH	TWICE PER MONTH	EVERY TWO WEEKS	WEEK
1	20,147	1,679	840	775	388
2	27,214	2,268	1,134	1,047	524
3	34,281	2,857	1,429	1,319	660
4	41,348	3,446	1,723	1,591	796
5	48,415	4,035	2,018	1,863	932
6	55,482	4,624	2,312	2,134	1,067
7	62,549	5,213	2,607	2,406	1,203
8	69,616	5,802	2,901	2,678	1,339
For each additional family member, add	7,067	589	295	272	136

"AND JUSTICE FOR ALL"

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. (Not all prohibited bases apply to all programs.)

To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

De acuerdo a lo establecido por las leyes Federales y el Departamento de Agricultura de los EE.UU. (USDA, siglas en inglés), se prohíbe a este organismo la discriminación por raza, color, origen nacional, sexo, edad, o impedimentos de las personas. (No todos las bases de prohibición se aplican a todos los programas.)

Para presentar una queja sobre discriminación, escriba a USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410, o llame al (202) 720-5964 (voz y TDD). USDA es un proveedor y empleador que ofrece oportunidad igual a todos.

CHILD AND ADULT CARE FOOD PROGRAM: CHILD CARE COMPONENT
INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED PRICE MEALS FY 2011 – 2012

FY2011 – FY2012 (7/1/11 – 6/30/12) INSTRUCTIONS: To apply for free and reduced price meals, read the Household Letter and instructions on backside of this form. Complete application and return to the center. In accordance with the NSLA, information on this application may be disclosed to other Child Nutrition Programs or applicable enforcement agencies. Parents/guardians are not required to consent to this disclosure. *Part 1* is to be completed by all households. *Part 2* is to be used only for a child living in a household receiving Food Assistance or Ohio Works First (OWF) benefits. *Part 3* is only for children NOT receiving Food Assistance or OWF benefits. *Part 4 an a*dult household member must sign and date form; the last 4 digits of social security number must be listed if Part 3 is completed. *Part 5* is optional. * Asterisks indicate info that must be completed. Form must be completed annually and is valid for only 12 mo.

PART 1 – PRINT INFORMATION FOR ALL CHILDREN ENROLLED AT CENTER * NAME OF ENROLLED CHILD(REN)	* AGE	* BIRTH DATE	**CHECK IF A FOSTER CHILD (the legal responsibility of a welfare agency or court).**	**PART 2 – LIST EACH CHILD'S FOOD ASSISTANCE OR OWF CASE NUMBER, IF ANY. A VALID CASE NUMBER CONTAINS 10 OR 12 DIGITS. DO NOT USE SWIPE CARD NUMBER.** Circle type of benefit: FOOD ASSISTANCE or OWF
1.			☐	CASE NUMBER: __ __ __ __ __ __ __ __ __ __ __ __
2.			☐	CASE NUMBER: __ __ __ __ __ __ __ __ __ __ __ __
3.			☐	CASE NUMBER: __ __ __ __ __ __ __ __ __ __ __ __
4.			☐	CASE NUMBER: __ __ __ __ __ __ __ __ __ __ __ __

PART 3 – TOTAL HOUSEHOLD SIZE, TOTAL HOUSEHOLD GROSS INCOME AND HOW OFTEN IT WAS RECEIVED: List names of all household members. List all gross income: list how much and how often. If Part 2 is completed, skip to Part 4.

a. LIST NAMES OF ALL HOUSEHOLD MEMBERS INCLUDING CHILDREN LISTED ABOVE IN PART 1	b. CHECK IF NO/ZERO INCOME	c. GROSS INCOME during the last month (amount earned before taxes & other deductions) and HOW OFTEN IT WAS RECEIVED: Weekly, Every 2 Weeks, Twice a Month, Monthly, Yearly			
		1. Earnings from work before deductions	2. Welfare payments, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA	4. All Other Income
1.	☐	$_________/_______	$_________/_______	$_________/_______	$_________/_______
2.	☐	$_________/_______	$_________/_______	$_________/_______	$_________/_______
3.	☐	$_________/_______	$_________/_______	$_________/_______	$_________/_______
4.	☐	$_________/_______	$_________/_______	$_________/_______	$_________/_______
5.	☐	$_________/_______	$_________/_______	$_________/_______	$_________/_______
6.	☐	$_________/_______	$_________/_______	$_________/_______	$_________/_______

PART 4 – SIGNATURE & LAST 4 DIGITS OFSOCIAL SECURITY NUMBER: Adult household member must sign/date form. If Part 3 is completed, the adult signing the form must also list last 4 digits of his/her Social Security Number or check the "I do not have a Social Security Number" box.

I certify that all information on this form is true and correct and that all income is reported. I understand that the center will get Federal Funds based on the information. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, I may be prosecuted.

*_______________________________________ **SIGNATURE OF ADULT HOUSEHOLD MEMBER**	*__________________ **DATE**	**If Part 3 is completed, insert last 4 digits of Social Security Number** ☐ ☐ ☐ ☐ ☐ **(check if applicable) I do not have a Social Security Number**
Print Name:	Daytime Phone Number:	Work Phone Number:
Street / Apt:	City / State / Zip:	County:

PART 5: RACIAL/ETHNIC IDENTITY (Optional): Please check appropriate boxes to identify the race or ethnicity of enrolled child(ren).

☐	American Indian or Alaska Native	☐	Asian	☐	Black or African American
☐	Native Hawaiian or Other Pacific Islander	☐	White	☐	Other

Please mark one ethnic identity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

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 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 the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program. **State Distribution: Week of 6/272011**

THIS SECTION TO BE COMPLETED BY CENTER: List name of site/center child(ren)attends:

No/Zero Income: 45 Day Temporary Free	Totals from Part 3, if completed:	
Free approval until : _____/ _____/_____ Sponsor must contact parent/guardian within 45 days of parent signature date to validate zero income and/or obtain new form. Date of parent contact: _____/_____/_____ 2nd Free approval until : _____/ _____/_____	Total Household Size ____________________ Total Monthly Income $____________________ Income Conversion : Weekly x 52, Bi-Weekly/Every 2 Weeks x 26, Semi-Monthly/Twice a Month x24, Monthly x 12	☐ **FREE** ☐ Food Assistance/OWF ☐ Household Size & Income ☐ Foster Child ☐ **REDUCED** ☐ **PAID** Reason: ☐ Income Too High ☐ Incomplete ☐ Invalid

______________________________	__________________	____________________	____________________
Signature of Center Official	Today's Date	Effective Date (No earlier than first of current month)	Expiration Date

OCN Revised 6/27/11

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Ohio Department of Education - Office for Child Nutrition **A**

CHILD AND ADULT CARE FOOD PROGRAM ENROLLMENT FORM

Only complete this form if your child is school age and meets income guidelines.

CACFP programs exempt from having an enrollment form on file are: Emergency Shelters, Outside-School-Hours, Youth Development & After School At Risk

Instructions for Completion

- All parents/guardians are to complete a separate form for each child enrolled at the child care or Head Start center.
- List the child's name, age, birth date, the days and hours normally in care and the meals normally received while in care. If schedule will vary in future due to changes in parent/guardian job schedule, indicate by writing a note on chart.
- If the child comes before and after school, list the hours in care for both the morning and afternoon.
- CACFP Federal regulations 226.15(e)(2) require that an enrollment form be **updated annually** and signed by the child's parent or guardian.

CENTER NAME		
CHILD'S NAME (please print)	**AGE**	**BIRTHDATE** / / month / day / year

CHECK THE NORMAL DAYS AND HOURS YOUR CHILD IS IN CARE AND THE MEALS RECEIVED WHILE IN CARE												
Check (✓) Days Child Normally in Care		List Hours Child Normally in Care				Check (✓) Meals Child Normally Receives while in Care						
		Arrive	Depart	Arrive	Depart	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Monday											
Tuesday											
Wednesday											
Thursday											
Friday											
Saturday											
Sunday											

SIGNATURE OF PARENT/GUARDIAN	**DATE**	**DAY PHONE NUMBER**
MAILING ADDRESS: STREET /APT.	**CITY**	**ZIP CODE**

In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).
USDA is an equal opportunity provider and employer. (rev. 2/23/11)

Ohio Department of Education - Office for Child Nutrition

CHILD AND ADULT CARE FOOD PROGRAM ENROLLMENT FORM

Only complete this form if your child is school age and meets income guidelines.

Prototype form for use by Child Care Centers and Head Start Programs when a center has daily parent sign-in and sign-out sheets that list the time children arrive and depart from the center.

CACFP programs exempt from having an enrollment form on file are:
Emergency Shelters, Outside-School-Hours, Youth Development & After School At Risk

* Asterisk indicates required information:

Instructions for Completion

- All parents/guardians are to complete a separate form for each child enrolled at the child care or Head Start center.
- List the child's name, age, birth date
- CACFP Federal regulations 226.15(e)(2) require that the enrollment form be **updated annually** and signed by the child's parent or guardian.

CENTER NAME		
CHILD'S NAME* (please print)	**AGE**	**BIRTHDATE** / / month / day / year

SIGNATURE OF PARENT/GUARDIAN *	**DATE ***	**DAY PHONE NUMBER**
MAILING ADDRESS: STREET /APT.	**CITY**	**ZIP CODE**

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Rev. 2/23/2011

CHARDON COMMUNITY DAY CARE CENTER
USDA FOOD PROGRAM WAIVER

Please review the guidelines for the United States Department of Agriculture food program on the previous pages.

If you DO qualify by meeting income guidelines listed on the "HOUSEHOLD LETTER on page 13, fill out the "INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED PRICE MEALS FY 2011-2012" and return to Chardon Community Day Care Center. Keep this page.

OR

If you DO NOT meet income guidelines listed on the "HOUSEHOLD LETTER" on page 13, fill out the bottom of this page and return to Chardon Community Day Care Center. Do not complete the "INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED PRICE MEALS FY 2011-2012".

I have reviewed the Reduced income Eligibility Guidelines Effective July 1, 2011 through June 30, 2012 and I DO NOT qualify for the USDA food program.

Parent Name (print): ______________________________________

Last First

Parent Signature: ________________________________ Date: ______________

RACIAL / ETHNIC IDENTITY (Optional)

Please check appropriate boxes to identify the race or ethnicity of ***each*** enrolled child

Child 1	First Name	Last Name
Please mark one ethnic identity:		*Please mark one racial identity:*
☐ Hispanic or Latino		☐ American Indian or Alaska Native
☐ Not Hispanic or Latino		☐ Asian
		☐ Black or African American
		☐ Native Hawaiian or Other Pacific Islander
		☐ White
		☐ Other

Child 2	First Name	Last Name
Please mark one ethnic identity:		*Please mark one racial identity:*
☐ Hispanic or Latino		☐ American Indian or Alaska Native
☐ Not Hispanic or Latino		☐ Asian
		☐ Black or African American
		☐ Native Hawaiian or Other Pacific Islander
		☐ White
		☐ Other

Use back of page for additional children if needed.

Child 3	First Name	Last Name

Please mark one ethnic identity:	*Please mark one racial identity:*
☐ Hispanic or Latino	☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ Asian
	☐ Black or African American
	☐ Native Hawaiian or Other Pacific Islander
	☐ White
	☐ Other

Child 4	First Name	Last Name

Please mark one ethnic identity:	*Please mark one racial identity:*
☐ Hispanic or Latino	☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ Asian
	☐ Black or African American
	☐ Native Hawaiian or Other Pacific Islander
	☐ White
	☐ Other

Child 5	First Name	Last Name

Please mark one ethnic identity:	*Please mark one racial identity:*
☐ Hispanic or Latino	☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ Asian
	☐ Black or African American
	☐ Native Hawaiian or Other Pacific Islander
	☐ White
	☐ Other

County Name	Clinic Name	Address	City	Zip Code	Phone Number	Hours of Operation
Fulton	Deshler WIC Program	101 East Main Street	Deshler	43516	419-278-9988	2nd & 4th M 1:00 - 4:00
Gallia	Gallia County WIC Program	499 Jackson Pike Suite D	Gallipolis	45631	740-441-2977	M - F 8:00 - 4:00
Geauga	Geauga County WIC Program	470 Center Street Building 8	Chardon	44024	440-279-1936	M, W & Th 8:00 - 4:00
Geauga	Middlefield WIC Clinic	14999 South State Avenue	Middlefield	44062	440-279-1936	T 8:00 - 3:30
Geauga	Chagrin Falls Park Community Center	7060 Woodland Avenue	Chagrin Falls	44023	440-279-1936	2nd W 8:00 - 1:00
Greene	Greene County WIC Program	360 Wilson Drive	Xenia	45385	937-374-5600 x5651	M - F 8:00 - 4:00 2nd Th 11:30 - 7:30
	Fairborn WIC Program	600 Pierce Drive	Fairborn	45324	937-879-4093	M & W 8:00 - 11:30 & 12:30 - 4:00
Guernsey	Guernsey County WIC Program	326 Highland Avenue	Cambridge	43725	740-439-3577 x 248	M 8:00 - 5:30 T - F 8:00 - 4:30
Hamilton	Walnut Hills/Evanston WIC	2805 Gilbert Avenue	Cincinnati	45206	513-281-4116 x 2218	M, T, W & F 8:00 - 4:30 1st, 2nd & 3rd Th
Hamilton	Elm Street WIC	1525 Elm Street 1st Floor	Cincinnati	45202	513-352-3032	M 9:00 - 6:00 T - F 8:00 - 4:30
Hamilton	Cann Health Center WIC	5818 Madison Rd 1st Floor	Cincinnati	45227	513-263-8778	M, T, W & F 8:00 - 4:30 Th 9:00 - 6:00
Hamilton	WIC Millvale Hopple Health Center	2750 Beekman Avenue	Cincinnati	45225	513-352-3198	M 9:00 - 6:00 T, Th & F 8:00 - 5:00
Hamilton	WIC Northside Health Center	3917 Spring Grove Avenue	Cincinnati	45223	513-564-2180	M 9:00 - 6:00 T - F 8:00 - 5:00
Hamilton	Children's Hospital WIC	3333 Burnet Avenue Location B1023	Cincinnati	45229	513-636-5818	M 11:00 - 7:30 T - F 8:30 - 5:00
Hamilton	WIC Price Hill Health Center	2136 West 8th Street	Cincinnati	45204	513-357-2726	M, T, Th & F 8:00 - 5:00 W 9:00 - 6:00
Hamilton	Western Hills	4966 Glenway Avenue #301	Cincinnati	45238	513-251-4700	M, T, Th 8:30 - 5:00 W 11:00 - 7:00
Hamilton	Harrison WIC	10400 New Haven Road	Harrison	45030	513-367-5383	M - F 8:30 - 5:00

Ohio Department of Job and Family Services

CENTER PARENT INFORMATION
REQUIRED BY OHIO ADMINISTRATIVE CODE

The facility is licensed to operate legally by the Ohio Department of Job and Family Services. This license is posted in a conspicuous place for review.

A toll-free telephone number is listed on the facility's license and may be used to report a suspected violation of the licensing law or administrative rules. The licensing law and rules governing child care are available for review at the facility upon request.

The administrator and each employee of the facility is required, under Section 2151.421 of the Ohio Revised Code, ORC to report their suspicions of child abuse or child neglect to the local public children's services agency.

Any parent, custodian, or guardian of a child enrolled in the facility shall be permitted unlimited access to the facility during all hours of operation for the purpose of contacting their children, evaluating the care provided by the facility or evaluating the premises. Upon entering the premises, the parent, or guardian shall notify the Administrator of his/her presence.

Rosters of the names and telephone numbers of the parent or guardians of the children attending the facility are available upon request. The parent roster will not include the name or telephone number of any parent who requests that his/her name or telephone number not be included.

The licensing inspection reports and complaint investigation reports, for the current licensing period, are posted in a conspicuous place in the facility for review.

The licensing record including compliance report forms, complaint investigation reports, and evaluation forms from the building and fire departments are available for review upon request from the Ohio Department of Job and Family Services. The department's website is: http://jfs.ohio.gov/cdc/childcare.stm .

It is unlawful for the facility to discriminate in the enrollment of children upon the basis of race, color, religion, sex or national origin or disability in violation of the Americans with Disabilities Act of 1990, 104 Stat. 32, 42 U.S.C. 12101 et seq.

This information must be given in writing to all parents, guardians and employees as required in 5101: 2-12-30 of the Ohio Administrative Code.

FEES

Weekly Rates

Infants (6 weeks – 18 months)	$170.00
Toddlers (18 months – 36 months)	$155.00
Preschool (36 months – 5 years)	$139.00
School Agers (enrolled in or eligible for school)	$134.00

Daily rates (5 hours or more)

Infants	$40.00
Toddlers	$37.00
Preschool	$34.00
School Agers	$34.00

Half Day Rate (5 hours or less)

Infants	$31.00
Toddlers	$29.00
Preschool	$27.00
School Agers	$27.00

Preschool Only: $120.00 per month – 2 days per week
$180.00 per month – 3 days per week

Before and After School Only: $5.00 per hour

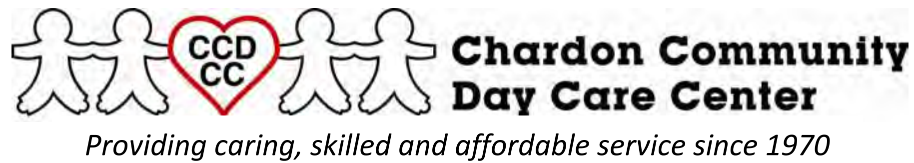
Registration Fee: $50.00 per family annually

Supply Fees: $5.00 per month per child, excluding infants

Van Fee (Burton, Cardinal, St. Helens & Hambden): $30.00 per month for 1 child, $40 per month for each additional child

Chardon Community Day Care Center
12797 Mayfield Rd.
Chardon, OH 44024
(440) 286-4135 phone
(440) 286-8286 fax
ccdcc@live.com
www.chardondaycare.org

A Program of



Providing caring, skilled and affordable service since 1970

Thank you for choosing Chardon Community Day Care Center for your family's Early Childhood Education needs!

12797 Mayfield Rd. Chardon, OH 44024 (440) 286-4135
www.chardondaycare.org ccdcc@live.com
www.facebook.com/chardondaycare