505 East First Street, P.O. Box 374
Huntingburg, IN 47542
Phone 812-683-2755 • Fax 812-683-8595
akidsplace2@gmail.com

2018-2019 Before and After School Program Information

A Kid's Place is pleased to partner with the Dubois County School Corporation to provide additional childcare opportunities for school age children throughout the school year. We are grateful for the opportunity to give our parents extended care options and better assist our families with their childcare needs.

Dates and Hours of Operation

- The Before/After School Program will begin on Thursday, August 9, 2018, and end on Friday, May 24, 2019. *(our Summer Care Program will begin immediately after the end of the school year, on May 25, 2019)*

- Before School hours: 5:45 am - 7:30am ET
- After School hours: 3:00pm - 6:00pm ET

- We will also provide childcare during No School Days (which include inclement weather days, make-up days and Professional Development days) from 5:45 am - 6:00pm ET. A detailed calendar will be distributed by August 1.

Meals

- Breakfast will be provided by Huntingburg Elementary School and an afterschool snack will be provided by a Kid's Place for the Before/After School Program during school days.

- Breakfast, morning snack, lunch, and afternoon snack will be offered for the program during No School Days.

Enrollment

- Enrollment fees are due prior to the start of the Before/After School program. If your child was enrolled in the 2018 Adventure Planet Summer Program, or our preschool program, the enrollment fee is waived for the Before/After School Program.

- Enrollment packets may be picked up at A Kid's Place or Huntingburg Elementary School. If you are enrolled in 2018 Adventure Planet Summer Program, you are exempt from completing an additional packet. Please let the Site Supervisors know or contact Deanna at A Kid's Place 812.683.2755 if you are interested in participating in our Before/After School Program as well.

- All completed enrollment packets must be submitted by **August 1, 2018**, to ensure enough time to process all the paperwork. If you need an extension, please contact Deanna.

Tuition

- Tuition Rates are based on a Tier System and align with the Income Eligibility Guidelines. Information about these guidelines is included in the enrollment packet.

- Please indicate in the enrollment packet if you plan to enroll for the full week rate, or daily rate.

- Tuition payment is due by COB on Fridays. We accept cash or checks. Please make checks payable to A Kid's Place.

- Scholarships are available for tuition assistance and we encourage families to apply for financial aid if needed. The deadline for all scholarship applications is **August 1, 2018**. Families will be notified of financial aid determinations by August 7, 2018. Late applications may be considered, depending on funding levels.

- Information on scholarships and tuition rates are attached.

More information will be distributed to registered families prior to the beginning of the school year. Please do not hesitate to contact A Kid's Place with questions, or requests for additional information.

Thank you and welcome to A Kid's Place Before/After School Program!

Deanna Vonderheide

Deanna Vonderheide,
Director, A Kid's Place

naeyc Accredited

Paths to QUALITY™
Better Child Care. Brighter Futures.
Level 4 Provider

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Huntingburg, IN 47542
Phone 812-683-2755 • Fax 812-683-8595
akidsplace2@gmail.com

2018-2019 Before and After School Rates

Before School Only

	Daily	Weekly	Sibling
Tier 1	$8.00	$35.00	$33.00
Tier 2		$25.00	$23.00
Tier 3		$15.00	$13.00

After School Only

	Daily	Weekly	Sibling
Tier 1	$10.00	$45.00	$43.00
Tier 2		$33.00	$30.00
Tier 3		$18.00	$15.00

Before and After School

	Daily	Weekly	Sibling
Tier 1	$15.00	$60.00	$53.00
Tier 2		$43.00	$40.00
Tier 3		$24.00	$20.00

Enrollment fees

Tier 1	$40.00/child	$60.00 family
Tier 2	$20.00/child	$30.00 family
Tier 3	$0.00	

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2018-2019 Before and After School Program

Child's Name: _____

My child will attend:

____ Before School Only

____After School Only

____Before AND After School

My Child will attend:

___At the full week tuition rate

___At the Drop In Daily Rate (applies to Tier One only)

Parents Signature _____ Date_____

Please submit by August 1 2018

naeyc Accredited

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Better Child Care. Brighter Futures.
Level 4 Provider

School Age Program Scholarship Application

Personal Information

Name: _____ Phone number: _____

Address: _____ Email: _____

City: _____ State: _____ Zip _____

*List names of dependents you claim on your Federal Income tax return

Name: _____ Date of birth _____

Name: _____ Date of birth _____

Name: _____ Date of birth _____

Name: _____ Date of birth _____

Name: _____ Date of birth _____

*Applicant/Primary Employment Information

Company's name: _____ Work # _____

Years/Months employed: _____ years _____ months Weekly Hours Worked: _____

Annual Wages: _____

*Spouse/Secondary Employment Information

Company's name:_____ Work #_____

Years/Months employed:_____years_____months Weekly Hours worked:_____

Annual Wages:_____

*Monthly Income

Income from Employment (self) _____

Income from Employment (Spouse/secondary) _____

Child Support Received _____

Social Security/Disability Received _____

Welfare/SNAP Benefits _____

Unemployment Benefits Received _____

Alimony Received _____

Other _____

*Monthly Expenses

Mortgage/Rent _____

Auto Loans _____

Child Support Paid _____

Medical _____

Utilities _____

Other _____

*Please provide information with reasoning as to why you are requesting financial assistance.

My signature below affirms the preceding information is true. I understand the information will be used confidentially by authorized personnel for consideration in granting financial assistance. I understand that I must notify A Kids Place of any changes in family or financial status immediately.

Applicant Signature

Date

COMMUNITY DAY CARE CENTER
d/b/a "A Kid's Place Daycare"
Parent Notification/Child Pick-up

ıild's Name _____ D.O.B _____

ɔme Phone _____ Cell Phone _____

other/Guardian _____ Work Phone _____

ther/Guardian _____ Work Phone _____

rst Parent to contact in case of emergency _____

ɔecial needs/allergies of child _____

_____

If unable to contact parents, please notify

_____

Name Relationship Phone #

_____

Name Relationship Phone #

_____

Name Relationship Phone #

ıe following have permission to pick up _____ from A Kid's Place

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship

_____ _____ _____ _____

ɜrent/Guardian Signature Date Parent/Guardian Signature Date

Community Day Care Center d/b/a

"A Kid's Place"

Admission Application

Child's Name _____ Birthdate _____

Name by which child is often called _____

Race _____ Sex _____

Address _____ Phone _____

City _____ State _____ Zip Code _____

Shirt Size XS S M L XL

Mother/Guardian's Name _____

Address (If different from child's) _____

Phone (If different from child's) _____ Cell Phone _____

Place of Employment _____ Phone _____

Employer's Address _____

E-mail Address _____ Normal Work Hours _____

Father/Guardian's Name _____

Address (If different from child's) _____

Phone (If different from child's) _____ Cell Phone _____

Place of Employment _____ Phone _____

Employer's Address _____

E-mail Address _____ Normal Work Hours _____

If applicable, legal custody has been awarded to _____.
(Please provide copy of court order)

Special instructions for contacting parents _____

_____

Other Adults in Family (Names & Relationships) _____

_____

Community Day Care Center, Inc. d/b/a

A Kid's Place

MEDICAL & EMERGENCY INFORMATION

Child's Name: _____

Home Phone Number: _____ Cell Phone: _____

Mother's Name: _____ Work Phone: _____

Father's Name: _____ Work Phone: _____

Health Insurance Carrier: _____ Policy #: _____

Name of Insured: _____

**Contact _____ first in case of emergency.

I, _____, authorize the staff of Community Day Care Center, Inc. d/b/a A Kid's Place to give medical and insurance information for emergency medical treatment and transportation arrangements. I understand that in the event of a medical emergency that requires medical treatment, A Kid's Place will arrange for an ambulance to transport my child for emergency medical treatment to Memorial Hospital. (This would be done in the event that neither parent could be contacted).

Furthermore, I, _____ realize that Community Day Care Center, Inc. d/b/a A Kid's Place will not be held responsible for any payments/bills due as a direct result of an accident or injury that occurs on daycare property or while your child is under our care.

Family Physician _____ Phone # : _____

Family Dentist _____ Phone #: _____

Child's known allergies: _____

Child's special health needs or chronic illnesses: _____

Child's last tetanus toxoid: _____

If unable to contact parents please notify:

Name	Phone Number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

We strongly advise all parents to go to the emergency room at Memorial Hospital and fill out an emergency consent form for each of their children. This form is valid for one year and allows treatment in emergencies when parents cannot be reached.

_____ Date _____ Date

Parent/Guardian Signature Parent/Guardian Signature

PARENT AGREEMENT:

Your signature below will confirm your understanding that:

1. Your fees are due each Friday for care the following week. Payments must be by check, money order, cash, or automatic withdrawal from a checking or savings account.

2. You are responsible for picking up your child(ren) by center closing time (6:00 pm) each day. Late fees will be assessed after stated closing time.

3. Children will be released only to a parent or a person named by the parent who has proper identification. Parent or persons named by the parent must make sure that a staff member is aware of the child's arrival and departure by signing the child(ren) in and out by their name and arrival and departure times.

4. You have received a copy of the Parent Handbook, which contains policies and other limitations.

5. You agree to cooperate with the A Kid's Place staff in all matters concerning the care of your child(ren) during the time they are enrolled at A Kid's Place.

6. A Kid's Place agrees to keep all family and child(ren) records confidential. Only administrative staff and teaching staff in direct contact with your child will be allowed access to your confidential information.

7. Should you choose to withdraw your child(ren) from A Kid's Place, you must submit a two week notice of withdrawal to the Center Director or Assistant Director.

_____ _____

Signature of Parent or Guardian Date

Parent MUST sign the child(ren) in and out noting time of arrival and/or departure.

_____ _____

Signature of Center Representative Date

Permission to Use Preventive Products

I, _____, the parent/guardian of
Parent's printed name

_____ _____
Child's printed name Child's birthdate

give permission for Community Day Care Center, Inc. d/b/a A Kid's Place to use the following preventive products for my child. I understand that I need to provide any products used. I also understand that this agreement is good for one year and may be revoked at anytime by myself or A Kid's Place. Please list the name of the product you are providing.

_____ _____ _____
Diaper Ointment (such as A&D or petroleum jelly) Parent's signature Date

_____ _____ _____
Sunscreen Name Parent's signature Date

_____ _____ _____
Insect Repellent Parent's signature Date

Photograph Authorization

I, _____(parent's or guardian's name) give permission for Community Day Care Center, Inc. d/b/a A Kid's Place to photograph my child, _____(child's name) for the following purposes:

(Please initial next to each that you grant permission. If you decline permission, do not initial.)

Still photographs

_____ Display at center

_____ Use in promotional materials

_____ Post on A Kid's Place facebook page and/or webpage

I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment. By signing below, I also agree that this is a legally binding form, and providing false information could be grounds for termination of childcare services.

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Date

Consent for Child Care Program Activities

Name of Child Care: A Kid's Place

Address of Facility: 505 East 1st Street, Huntingburg, IN 47542

Name of Child: _____

Parental/ Legal Guardian Consent is given for the items below: (please initial)

Walking Trips

_____ Walking trips to the following locations:
Neighborhood, city park, city library, 4th Street, playing in side yard (between daycare and police station)

Swimming

_____Swimming and/or wading at:
(location) Huntingburg City Pool

_____

Print Legal Guardian's Name: _____

Legal Guardian's Signature: _____

Date: _____

CHILD INFORMATION SHEET

Child's Name_____ Date:_____

CHILD'S HOME SETTING

Do you live in an apartment? _____ a house?_____ other?_____

How many times has your child moved? _____

Does your child share a room? _____

If father/mother is out of the home, how often does your child see him/her?

_____

CHILD'S GROUP EXPERIENCE

Indicate types of group experiences your child has had, or is having now, the dates of these experiences (i.e. daycare, nursery school, Sunday school, etc.)

Types of Experience:	*Date:*
_____	_____
_____	_____
_____	_____

CHILD'S INTERESTS AND ACTIVITIES AT HOME:

Child's Playmates:	*Sex:*	*Age:*
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does your child prefer to play alone? _____ with playmates? _____

with brothers/sisters? _____

Does your child have imaginary playmates? _____

Does your child have any pets? _____ If yes, what? _____

What are your child's favorite toys, play equipment, and books?

_____

_____

What kind of activities do you do together as a family?

_____

_____

City of Huntingburg Transit
508 E. 4th Street
P.O. Box 10
Huntingburg, IN 47542

812-683-2211
812-683-5661fax
jlueken@huntingburg-in.gov

CITY OF HUNTINGBURG – TRANSIT CONSENT FORM

For Passengers Under the Age of 18

It is the policy of the City of Huntingburg Transit that anyone under the age of 18 must have the consent of their parent or guardian before transportation is provided. The parent or guardian must appear at the Huntingburg City Hall to complete consent form and provide photo identification. Transportation arrangements must be made by the parent or guardian.

PASSENGER NAME: _____

ADDRESS: _____

_____

PHONE: _____

PARENT(S) or GUARDIAN(S) NAME: Mother: _____

Father: _____

ADDRESS: _____

_____

PHONE: (home) _____

(work) _____

Emergency Number(s) _____

DAYCARE PROVIDER: _____

ADDRESS _____

_____

PHONE: _____

I give my daycare provider permission to schedule transportation for my child: _____YES

_____NO

SIGNATURE PARENT/GUARDIAN: _____ DATE_____

Consent Form Expires One (1) Year From the Signature Date Above. Consent Form Must be Renewed Annually.

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 childcare homes and centers across the country. Providers are reimbursed for serving nutritious meals that 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 after school care programs in needy areas.

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

Sponsoring Organization/Center

Community Day Care Center, Inc.
d/b/a A Kid's Place
505 East 1st Street
P.O. Box 374
Huntingburg, IN 47542
(812) 683-2755

Indiana Department of Education

CACFP Staff
School & Community Nutrition
151 West Ohio Street
Indianapolis IN 46204
800-537-1142 or 317-232-0850

I:Building for the Future ENG

English Version

CACFP Application for Free and Reduced Price Meals (Child Care)

Sponsor Name:	Phone Number:
Center:	FDC Provider:

Part 1. All Household Members

Names of all household (First, Middle Initial, Last)	Birth Dates of Children	Check if a foster child (the legal responsibility of a welfare agency or court) * If all children listed below are foster children, skip to Part 4 to sign this form.	Check if NO income
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

Part 2. Benefits: If any member of your household received [Food Stamps] or [State TANF cash assistance], provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to Part 3.**

Name: _____ Case number: _____

Part 3. If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call [Insert center contact and phone number] Homeless ☐ Migrant ☐ Runaway ☐

Part 4. Total Household Gross Income—You must tell us how much and how often Check if NO income ☐

A. Name (List only household members with income)	B. Gross income and how often it was received 1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All other income
(Example) Jane Smith	$200/weekly	$150/twice a month	$100/monthly	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: XXX - XX - _ _ _ _ ☐ I do not have a Social Security Number

_____ Initial here if you consent to allow [Provider's Name] to collect your form and provide it to the Sponsor. [Provider's Name] will not review your form.

Part 6: Other Benefits: The LAs allows us to tell Medicaid and Hoosier Healthwise that your children are eligible for free or reduced price meals. We may share your application information with Medicaid or Hoosier Healthwise unless you do not want us to. If you do not want us to share this information, please sign here:

_____ For Information about Hoosier Healthwise health insurance

Signature of Parent or Guardian Call 1-800-889-9949

CACFP Application for Free and Reduced Price Meals (Child Care)

A child enrolled in the day care facility may qualify for free or reduced price meals if the household income falls at or below the limits on this chart:

July 1, 2018 to June 30, 2019			
Household Size	Monthly Income	Household Size	Monthly Income
1	1,872	5	4,536
2	2,538	6	5,202
3	3,204	7	5,868
4	3,870	8	6,534
For each additional family member, add **$666**			

Part 7. Participant's Ethnic and Racial Identities (Optional)

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino	☐ Asian	☐ American Indian or Alaska Native
	☐ White	☐ Native Hawaiian or Other Pacific Islander
☐ Not Hispanic or Latino	☐ Black or African American	

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.

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.

This institution is an equal opportunity provider.

Child Care Representative Use Only

Annual Income Conversion: Weekly X 52 – Every 2 Weeks X 26 – Twice a Month X 24 – Monthly X 12

Section A *Mark one of the boxes below to show how you are going to determine eligibility.*

☐ **Food Stamp or TANF Household**—The Food Stamp or TANF number meets the criteria for an acceptable case number. Complete Section B & C

OR

☐ **Foster Child**—Compare the foster child's personal income to the guidelines. Complete Section B & C

OR

☐ **Household Income**—Complete the information below and Complete Section B & C

Total Household Size: _____

Total Household Income

$_____/_____

Example: $100/week

Compare total household income to current USDA Income Eligibility Guidelines. When the household incomes are listed for different pay periods, you must convert all income to monthly or annual income. Use the conversion listed above.

Section B

Based on the information provided, this application will be:

☐ Approved Free ☐ Approved Tier I

☐ Approved Reduced ☐ Approved Tier II

☐ Paid

Use this space for income calculation.

Section C

_____

Signature of Sponsor Representative

_____

Date of Approval

This form expires one year from the date it was approved

CHILD ENROLLMENT FORM

IDOE/CACFP
July 2017

Name of Institution: __________ Sponsor ID Number: 119011D

Name of Facility: A Kids Place

Child's Name: __________ **Birthdate:** __________

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Please enter the normal hours your child is in care on the specific days of care.							
Please check (√) the meals your child normally receives while in care.	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__
If your school-age child will be in attendance outside of the regular hours indicated above (snow days, school breaks, etc.) Please check (√) here ______							

FOR INFANTS ONLY: All facilities must offer infant formula and meals/snacks to infants in care during meal service times

Infant Formula

This facility will provide the following iron-fortified infant formula: __________

Check here to accept: ☐ Check here to decline: ☐ Provide name of parent-provided formula: __________

Infant Meals and Snacks

Check here to accept: ☐ Check here to decline: ☐

This information is required by CACFP federal regulations at §226.15 (e)(2) and (3) for each enrolled participant, and must be updated annually.

Printed name of parent/guardian: __________ Phone Number: __________

Signature of parent/guardian: __________ Date: __________