

{The Valley Child Development Center}

2024

Making Learning Fun. Affordably. Professionally. Happily.
Red Cloud, NE

500 West A Ave. Red Cloud, NE 68970 402-746-5110 valleychild.org thevalleychild@gmail.com

Child Enrollment Information (one form to be filled out per child):

First Name _____ Last Name _____ Circle _____ MM/DD/YY _____

M/F

DOB: _____

Enrollment Date: _____

Was this child born premature? (<37 weeks) Yes/No

Child's Social Security #: _____

Ethnic/Racial Identity: Is this child Hispanic or Latino? Yes/No

What is this child's race? (You may check more than one)

American Indian or Alaska Native _____ Asian _____ Black or African American _____

Native Hawaiian/Other Pacific Islander _____ White _____

What is this child's primary language? _____

Does this child speak or hear a language other than English in their home? If yes, what? _____

Parent/Guardian Information:

First Name _____ Last Name _____ Circle _____ MM/DD/YY _____

Parent/Guardian 1:

M/F

DOB: _____

Relation to child: _____

Mailing address:

Street _____

Lives with child? Yes/No

City _____

State _____

Zip _____

Cell Phone: _____

Email address: _____

Home Phone: _____

Employment Name: _____

Employer Phone Number: _____

Employment Status: Full-time _____ Part-time _____ Temporary _____ Seasonal _____

(check all applicable) Unemployed _____ Student _____

Avg hours

worked weekly: _____

Military Service: Yes/no

Highest level of education completed: _____

First Name _____ Last Name _____ Circle _____ MM/DD/YY _____

Parent/Guardian 2:

M/F

DOB: _____

Relation to child: _____

Mailing address:

Street _____

Lives with child? Yes/No

City _____

State _____

Zip _____

Cell Phone: _____

Email address: _____

Home Phone: _____

Employment Name: _____

Employer Phone Number: _____

Employment Status: Full-time _____ Part-time _____ Temporary _____ Seasonal _____

(check all applicable) Unemployed _____ Student _____

Avg hours

worked weekly: _____

Military Service: Yes/no

Highest level of education completed: _____

Family Handbook and Parent Information Brochure for Licensed Child Care:

I have received and reviewed The Valley Child Development Center (TVCDC) Family Handbook and I have received the Parent Information Brochure for Licensed Child Care from the Division of Public Health. It is my responsibility to understand and familiarize myself with the Family Handbook and to ask center management for clarification of any policy, procedure or information contained in the TVCDC Family Handbook that I do not understand.

Signature of Parent/Guardian: _____

Date: _____

For Office use: _____ Registration Fee _____ Enrolled in Procare _____ Procare App
_____ Vaccinations _____ CACFP _____ Contract _____ Front Door

Continued on back side

Child's Name: _____ DOB: _____

Local Person to whom the child may be released to (AT LEAST ONE CONTACT MUST BE GIVEN):

	First Name _____	Last Name _____	
Contact 1:	_____		Relation to child: _____
Mailing address:	Street _____		
	City _____	State _____	Zip _____
			Cell Phone: _____
Email address:	_____		Home Phone: _____
May be released by caregiver:	Yes/No _____	Emergency Contact:	Yes/No _____

	First Name _____	Last Name _____	
Contact 2:	_____		Relation to child: _____
Mailing address:	Street _____		
	City _____	State _____	Zip _____
			Cell Phone: _____
Email address:	_____		Home Phone: _____
May be released by caregiver:	Yes/No _____	Emergency Contact:	Yes/No _____

Consent to Contact Physician in Emergency:

In the event I cannot be reached in an emergency to make arrangements, I hereby give my consent to The Valley Child Development Center to contact my child's doctor or emergency services for any necessary medical treatment.

Child's Physician:	_____	Phone:	_____
Signature of Parent/Guardian:	_____	Date:	_____

Child's Medical Information:

Current health status or any health problems caregiver should know about my child: _____

Daily Medications: Yes/No Please list: _____

I, _____ (Parent/Guardian) have determined that The Valley Child Development Center is competent to give or apply medication to my child.

Signature of Parent/Guardian:	_____	Date:	_____
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Allergies: Yes/No Please List: _____

Other important information for teacher to know: _____

Permissions:

TVCDC will apply sunscreen when playing outside. Please send in a bottle with your child's name on it. **I give permission for the sunscreen I have provided to be used on my child:** (circle) Yes/No

TVCDC has my permission to photograph and use my child's photograph publicly. I understand that the images may be used in print publications, online publications, presentations, websites, and social media. I also understand that no royalty, fee or other compensation shall become payable to me by reason of such use. **I give permission for my child to be photographed:** (circle) Yes/No

TVCDC has my permission to take my child off the child care premises ONLY with direct supervision. Possible activities outside of provider's premises: walks in the neighborhood, walks to the library or museum, school events, special neighborhood events. All activities will be within walking distance and children will be supervised at all times. **I give permission for my child to leave the premises:** (circle) Yes/No

TVCDC has my permission to share my child's file as needed, as it pertains to licensing and grants. **(circle)** Yes/No

I certify that the information on this form is correct to the best of my knowledge.

Signature of Parent/Guardian:	_____	Date:	_____
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{The Valley Child Development Center}

Payment Agreement

Child(ren)'s Name(s): _____

Parent/Guardian Name: _____

Date this agreement/change is to take effect: _____

My child will attend on the (circle one): 1-3 day contract or 4-5 day contract

My child's usual drop-off time will be: _____ and pick-up time will be: _____

If on the 3-day contract, circle which days your child will attend.

Monday Tuesday Wednesday Thursday Friday My schedule varies

If your schedule varies, you agree to provide your schedule 2 weeks ahead of time.

Payment Policy:

Payment is due by Friday evening for the following week's attendance. Payments are accepted weekly or monthly and can be paid with cash, check, credit card or automatic bank transfer.

If payment is not received on the day it is due, a late fee of \$5.00 will be added for each day it is late. If your account has not been paid within ten business days, your child may be discharged from the program.

At The Valley Child Development Center, we partner with Tuition Express to automate payments. No more worrying about checks, credit card payments or balances. Once you enroll, automatic payments will be deducted on Monday of each week, for the week's care. You can choose to connect Tuition Express to your checking, savings, or credit card account.

Please read and initial:

	Initial
I agree to enroll in Tuition Express and understand if my bill is not paid for the upcoming week by Friday evening, it will be automatically deducted on Monday morning of each week through automatic bank transfer.	
Credit card transactions have a 2.7% processing fee.	
Tuition is based on enrollment, not attendance. Fees are not reduced for absences.	
A late pick up fee of \$10 will be charged per child if in the building past 5:30 pm.	
A two-weeks' notice is required when withdrawing your child from TVCDC. If two weeks' notice is not given, two weeks tuition will be added to your bill.	
All returned checks or returned ACH transactions (automatic debits) will be charged a fee of \$20.00.	
Child tuition is the responsibility of both parents, regardless of family dynamics.	
Subsidy families will be required to pay out of pocket until subsidy paperwork is finalized.	
All families receiving State Subsidy child care will be charged their family fee (co-payment) if it applies. If attendance goes over state approved hours, you will be charged per hour over.	

Parent signature: _____ **Date:** _____

Dear Parent or Guardian:

Our child care institution has been approved by the Nebraska Department of Education for participation in the Child and Adult Care Food Program (CACFP). The CACFP reimburses our institution for the partial cost of meals. We are requesting your help to receive the maximum benefits from the CACFP by completing the attached form (NS)100-C.

The parent/guardian must complete Parts 1 and 4 and one of the following options: Part 2, Part 3A or Part 3B, to determine the amount of CACFP funds the center will be eligible to receive. **Note: No white out or erasure ink should be used.** If there is an error cross through, correct, and initial.

Part 1 - CHILD ENROLLMENT

- **Child's Name:** List the first and last name including nicknames and hyphenated last name for all children enrolled at this center.
- **Date of Birth:** List each child's date of birth.
- **Enroll Date:** List each child's enrollment date with the organization.
- **Usual Times & Days of Care and Meals Served:** List the usual times of care for each child by listing their arrival and leave time, check each day the child will be in care and each meal type received while in care.
- **Infant:** If the child is under 12 months of age, check box.
- **Foster Child:** If the child is a foster child (the legal responsibility of a foster care agency or the court), check the box.
- **Head Start:** If the child is eligible for head start, check box.
- **School age:** If the child is attending Kindergarten or above and attends your child care program before, after and/or school days off, check box.

Optional - Check the boxes of all appropriate race(s) and ethnicities regarding the child(ren) you are enrolling. If you do not select Race or Ethnicity, one will be selected for you based on visual observation. This does not affect your child's eligibility for Free or Reduced meals.

Part 2 - Household Receiving Benefits from the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR):

- Complete Parts 1, 2 and 4 on the attached form.
- Check the box(s) and provide case number for the program from which benefits are received.

Part 3A - Household exceeding the income guidelines listed on the chart below - Complete Parts 1, 3A and 4 on the attached form.

TO CALCULATE ANNUAL INCOME

Weekly Income X 52 ♦ Every 2 Weeks Income X 26 ♦ Twice a Month Income X 24 ♦ Monthly Income X 12

Household Size:	1	2	3	4	5	6	7	8	Each Additional Family Member
Annual Income:	\$27,861	\$37,814	\$47,767	\$57,720	\$67,673	\$77,626	\$87,579	\$97,532	+ \$9,953

Part 3B - Household below the income guidelines listed on the chart above - Complete Parts 1, 3B and 4 on the attached form using the additional information below:

- **HOUSEHOLD NAMES:** Write the names of everyone in the household not listed in Part 1. Include yourself and all other children, your spouse, grandparents, other relatives and unrelated people in your household. Use a separate sheet of paper if you do not have enough space.
- **GROSS INCOME BEFORE DEDUCTIONS:** Write the amount of income each person gets on the same line as their name. Use the appropriate column(s): Earnings from Work, Welfare/Child Support/Alimony, Pensions/Retirement/Social Security or Other Income (see definitions below). Next to the amount of income write how often the income is received. Income is all money before taxes or anything else is taken out. If a person does not have income, check the box for zero income.

OTHER INCOME: strike benefits, unemployment compensation, workman's compensation, disability benefits, interest/dividends, cash withdrawn from savings, income from estates/trust/investments, royalties/annuities/rental income, and regular contributions from persons not living in the household.

FOSTER CHILDREN: List any personal income received by the foster child under Part 3B. Personal income is (a) money given for the child's personal use, such as clothing, school fees and allowances and (b) all other money the child gets, such as money from his/her family.

MILITARY HOUSING BENEFITS: Report off-base housing allowance as income. If the housing is part of the Military Housing Privatization Initiative, do not include as income.

SELF-EMPLOYMENT: Report income derived from the business venture less operating costs for net income. The loss from the business cannot be deducted from a positive income earned in other employment. The least possible income is zero.

- **SOCIAL SECURITY NUMBER:** Write the last four (4) digits of the social security number of the adult household member who signs the form. If the adult household member does not have a social security number, check the box. Use of this information is for CACFP use only and is required.

Part 4 - SIGNATURE AND CONTACT INFORMATION:

- Sign and date the application. The form must be signed by the parent or guardian.
- Complete the contact information – name, address, e-mail address and telephone number.

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, the funds your child care/center/provider receives may be impacted. 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.

Non-Discrimination Statement:

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex (including gender identity and sexual orientation), 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, audiotope, 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.

For assistance completing this form, contact the center:

Center Name: The Valley Child Development Center

Address: 500 West A Ave

City, State, Zip: Red Cloud, NE 68970

Contact Person: Anne Romero

Telephone: 402-746-5110

E-Mail Address: tvcdc.office@gmail.com

The State Agency administering the Child and Adult Care Food Program is:

Nebraska Department of Education

Nutrition Services

P.O. Box 94987

Lincoln, NE 68509

Telephone: 402-471-2488

Website: <http://www.education.ne.gov/NS>

**INCOME ELIGIBILITY & ENROLLMENT FORM FOR CHILD CARE CENTERS
 JULY 1, 2024 THROUGH JUNE 30, 2025**

Part 1. CHILD ENROLLMENT: Complete the information below for all children in care. If the child is an infant, foster child (legal responsibility of a foster care agency or the court), Head Start eligible or a school-age child, please check the box.

Last Name, First Name	Date of Birth	Enroll Date	Times of Care (Usual)		Usual Days of Care							Meals Served During Care					Infant	School Age	Head Start	Foster Child	
			Arrival Time	Leave Time	M	T	W	T	F	S	S	B	A M	L	P M	D					E V
																		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
																		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
																		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
																		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OPTIONAL: Please check the ethnicity and race of the child(ren) you are enrolling.

- Ethnicity (select one or more): Hispanic or Latino Not Hispanic or Latino
- Race (select one or more): American Indian or Alaskan Native Asian Black or African American
- Native Hawaiian or other Pacific Islander White or Caucasian

Part 2. Household Receiving Benefits: Supplemental Nutrition Assistance Program (**SNAP**), Temporary Assistance for Needy Families (**TANF**), or Food Distribution Program on Indian Reservations (**FDPIR**): **Complete Parts 1, 2 and 4.**

Check Applicable Program & Provide Case Number(s): **SNAP Case #:** _____ **TANF Case #:** _____ **FDPIR Case #:** _____

Part 3A. HOUSEHOLDS EXCEEDING THE INCOME GUIDELINES: Complete Parts 1, 3A and 4.

If your family income exceeds the income guidelines (listed on attached letter), check this box

Part 3B. ALL OTHER HOUSEHOLDS – If you **do not** have a SNAP, TANF or FDPIR **MASTERCASE** number: Complete Parts 1, 3B and 4.

List the Names of All Household Members not listed in Part 1 and Foster Children	GROSS INCOME BEFORE ANY DEDUCTIONS (Net for Self Employed)								Check if ZERO income
	Earnings from Work		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		All Other Income		
	How much?	How often?	How much?	How often?	How much?	How often?	How much?	How often?	
1									<input type="checkbox"/>
2									<input type="checkbox"/>
3									<input type="checkbox"/>
4									<input type="checkbox"/>

Social Security Number of Household Member who signs form:

Last four digits of Social Security Number: XXX-XX - _____ If you do not have a Social Security Number, check this box

Part 4. SIGNATURE AND CONTACT INFORMATION:

I certify (promise) that all information on this form is true and that all income is reported. I understand that the facility will receive 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 their meal benefits, and I may be prosecuted.

Signature of Parent/Guardian Date

Print Name

Address

City State Zip Code

E-Mail Address/Telephone

FOR CENTER USE ONLY

_____ SNAP/TANF/FDPIR HOUSEHOLD

_____ ANNUAL INCOME: _____ HOUSEHOLD SIZE: _____

Center Official Signature Date of Signature

Effective Date Expiration Date

HOUSEHOLD CATEGORY:	<input type="checkbox"/> Free
	<input type="checkbox"/> Reduced
	<input type="checkbox"/> Paid
	<input type="checkbox"/> Incomplete
Foster Child – Free Category	
List name of foster child(ren)	
