2019-2020 FCCC SCHOOL YEAR ENROLLMENT PACKET

CHILD _____

FCCC SITE: ❒**BRADLEY** ❒**BRUMFIELD** ❒**C.H. RITCHIE** ❒**COLEMAN**
❒**GRACE MILLER** ❒**GREENVILLE** ❒**H.M. PEARSON** ❒**M.M. PIERCE**
❒**MARY WALTER** ❒**P.B. SMITH**

❒**LOCATION IF CHILD ATTENDS AN ALTERNATE SCHOOL:** _____

❒**ENROLLMENT FORM**

❒**ONE CALL NOW EMERGENCY NOTIFICATIONS** Emergency notifications will be sent to cell phones and e-mails on file, make sure your information is updated and legible on our paperwork. One cell phone number and one e-mail per parent.

❒**PAYMENT AGREEMENT**

❒**INCOME VERIFICATION FORM** Qualifying for a sliding scale tuition rate **(Step 1, Step 2 or Step 3)** requires proof of your annual **household** income. Your annual income includes all wages, child support, social security, etc**. T**wo most recent pay stubs and FCCC's Income Verification Form are required for proof of income. **You will be charged full fee tuition until required documentation is received and verified.**

❒**USDA SNACK FORM** Completed by all regardless of income

❒**HEALTH RECORDS** physical/well check + immunization records, both signed or stamped by physician

❒**ORIGINAL BIRTH CERTIFICATE** viewed for identity verification

❒**HOMEWORK TIME** Do you want your child to attend homework time? _____

❒**EMERGENCY MEDICATIONS** All enrollees with severe allergies, food or environmental, must have the appropriate paperwork and medication at FCCC.

❒Does your child require emergency medications? _____

❒**MAT FORM** ❒**EMERGENCY CARE ACTION PLAN FORM**

❒**ILLNESS POLICY PARENTAL AGREEMENT** Refer to Handbook for Illness Policy.

- FCCC will notify parents when their child becomes ill and arrangements shall be made for the child to be picked up as soon as possible.
- The Executive Director must be notified within 24 hours if a child or a member of the immediate household contracts a contagious illness. Life threatening diseases must be reported immediately.
- I authorize FCCC to obtain medical care if any emergency occurs when I cannot be immediately located.

Parent/Guardian Signature_____ Date _____

❒**PHOTO RELEASE**

- **I** hereby authorize Fauquier Community Child Care, Inc. (FCCC), hereafter referred to as "Company," to publish photographs taken of myself and/or the minor child or children listed above, and our names and likenesses, for use in FCCC's print, online, social media and video-based marketing materials, as well as other Company publications.
- **I** hereby release and hold harmless FCCC from any reasonable expectation of privacy or confidentiality for me and for the minor child or children listed above associated with the images specified above. Further, **I** attest that I am the parent or legal guardian of the child or children listed above and that **I** have full authority to consent and authorize FC CC to use their likenesses and names.
- **I** further acknowledge that participation is voluntary and that neither I, the minor child, nor minor children will receive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other Company publications. I acknowledge and agree that publication of said photos confers no rights of ownership or royalties whatsoever.
- **I** hereby release FCCC, its contractors, its employees and any third parties involved in the creation or publication of Company publications, from liability for any claims by me or any third party in connection with my participation or the participation of the minor children listed below.

Parent/Guardian Signature_____ Date _____

❒**HOW DID YOU HEAR ABOUT FCCC?** _____

FCCC USE ONLY: ❒**HANDBOOK** ❒**PAYMENT BOOK** ❒**PAYMENT AGREEMENT CONFIRMATION COPY**

Staff: _____ Date: _____

2019-2020 FCCC SCHOOL YEAR ENROLLMENT FORM

SITE _____

CHILD (Full Name) (Nickname) **BIRTHDATE** **GENDER** **GRADE** **TEACHER**

1 _____ Female / Male _____

2 _____ Female / Male _____

3 _____ Female / Male _____

PARENTS/GUARDIANS - Parent 1 is considered the enrolling parent.

Parent 1	Employer	Work Hours	Business Phone

Home Address City State Zip	Home Phone
Mailing Address, if different than Home: E-Mail Address:	Cell #

Parent 2	Employer	Work Hours	Business Phone

Home Address City State Zip	Home Phone
Mailing Address, if different than Home: E-Mail Address:	Cell #

Person(s) or Agency Having Legal Custody of Child *(Appropriate legal documentation shall be on file when a parent or the court system denies the non-custodial parent visitation or permission to pick up a child.)*	
Home Address	Home Phone
Business Address	Business Phone

EMERGENCY INFORMATION

Does your child have any allergies or sensitivities? If yes, what action should be taken in an emergency? *All enrollees with severe allergies, food or environmental, must have the appropriate paperwork and medication at FCCC.*
Does your child have any chronic physical or developmental difficulties? If yes, please provide appropriate documentation.
Has your child ever had an adverse reaction to insect repellant or sun block? ❍yes ❍no I authorize FCCC to apply sun block to my child when necessary. _____/_____ Parent Signature Date

Child's Physician	Phone

EMERGENCY CONTACTS - OTHER THAN PARENTS (2 REQUIRED).	
1. Name: Address:	1. Phone
2. Name: Address:	2. Phone

Person(s) Authorized to Pick Up Child(ren):
Person(s) NOT Authorized to Pick Up Child(ren):

If Child Attends this Center & Another School/Program, Give Name of School/Program:	Grade

Previous Child Day Care Programs & Schools Attended:

FCCC USE ONLY:

Birth Certificate #: _____ State/Country Issued: _____ Date Issued: _____ Viewed By:_____

2019-2020 FCCC SCHOOL YEAR PAYMENT AGREEMENT

CHILD_____ SITE_____

A $55.00 Non-Refundable Registration Fee + First Month's Tuition is due at the time of enrollment.
REGISTRATION IS NOT COMPLETE UNTIL PAYMENT IS RECEIVED. Tuition is pro-rated for August.

● FULL-TIME MONTHLY CARE: Circle Household Size and Yearly Income, Choose Type of Care. (Monthly Fee)

Household Size	Full Fee Income	Step 1	Step 2	Step 3
	____ **Before School Only - $186** ____ **After School Only - $243** ____ **Combined - $379**	____ **Before School Only - $136** ____ **After School Only - $176** ____ **Combined - $276**	____ **Before School Only - $98** ____ **After School Only - $127** ____ **Combined - $199**	____ **Before School Only - $66** ____ **After School Only - $85** ____ **Combined - $135**
2	above $33,572	$33,571 - $24,327	$24,326 - $15,081	below $15,080
3	above $41,749	$41,748 - $32,504	$32,503 – $23,258	below $23,257
4	above $49,926	$49,925 - $40,681	$40,680 - $31,435	below $31,434
5	above $58,103	$58,102 - $48,858	$48,857 - $39,612	below $39,611
6+	above $66,280	$66,279 - $57,035	$57,034 - $47,789	below $47,788

- Qualifying for a sliding scale tuition rate **(Step 1, Step 2 or Step 3)** requires proof of your annual **household** income. Your annual income includes all wages, child support, social security, etc. Two most recent pay stubs and FCCC's Income Verification Form are required for proof of income. **You will be charged full fee tuition until required documentation is received.**
- When a family enrolls more than one child a 10% discount is applied to the fee that is of equal or lesser value.

● PART-TIME MONTHLY CARE (3 DAYS A WEEK): Choose Type of Care and three days to attend.

_____	Before School - $119/month	M	T	W	R	F
_____	After School - $156/month	M	T	W	R	F
_____	Combined - $245/month	M	T	W	R	F

- Full-Time Monthly Care packages cannot be combined with Part-Time Monthly Care packages.
- Punch Cards can be used to supplement occasional care.

● PUNCH CARD (OCCASIONAL CARE): Choose Type of Care.

_____Before School _____After School _____Combined

- I understand that a Punch Card has 10 hours of care for $145 and any portion of an hour used will constitute the use of an entire hour, per child. I understand Punch Cards are non-refundable and can only be transferred between siblings. I also understand that I must provide FCCC 24-hour's notice prior to using the Punch Card, send a note to my child's teacher allowing their release to FCCC and that all other FCCC policies apply. *I understand the Punch Cards cannot be used for the following types of care: Delayed Openings, Half-Days, Holiday Care, Inclement Weather Care or Teacher Work Days.*
- Punch Cards expire 12 months from the issue date. Accounts are charged for a new Punch Card when the current one expires unless written notice is provided in accordance with FCCC's withdrawal policy to terminate Punch Card enrollment.

❒I authorize FCCC to discuss account information with both parents listed on the enrollment form. I understand that in order to rescind this authorization I must provide the FCCC main office with a written statement.

❒**Withdrawal from the program must be received, in writing, a minimum of two weeks prior to the last date of the child's attendance. Fees are due for the entire withdrawal period and will be pro-rated if it carries over into the next month.**

❒Residing County ❍Culpeper ❍Fauquier ❍Madison ❍Orange ❍Prince William ❍Rappahannock ❍Other_____

❒By signing below I grant my child permission to participate in the FCCC School Year Program and all activities. I agree to hold FCCC, its agents, employees and volunteers harmless from all action, damages, claims or demands and all liability that might arise as a result of my child's participation in the FCCC School Year Program. In addition, I give FCCC permission to take steps to provide medical attention should the participant be injured.

I have read and understand all terms stated above.

_____ _____/_____
Parent/Guardian PRINTED Name Parent/Guardian Signature Date

❒**I would like to make a donation of $_____ to help a child in need attend FCCC.** *(Please pay separately from tuition.)*

FCCC USE ONLY:

Accepted by: _____ Date Received _____ Amount Paid $_____ ❒Check/MO # _____

Date Child Entered Care _____ Date Child Left Care _____ ❒Cash / Receipt # _____

MAIN OFFICE USE ONLY:

Processed by: _____ Date _____ ❒CHECKED FOR OUTSTANDING BALANCE $_____

CHILD AND ADULT CARE FOOD PROGRAM
MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care) / FISCAL YEAR 2019
PARENT LETTER

Dear Parent or Guardian:

This child care center participates in the United States Department of Agriculture Child and Adult Care Food Program (CACFP) and receives Federal Funds to provide healthy meals and snacks to all of the enrolled children. The amount of reimbursement the center receives is based on the information provided on the attached CACFP Meal Benefit Income Eligibility Form (IEF). Part of the USDA requirement is to complete the IEF. If household income is equal to or less than the income listed in the chart below for household size, the center will receive a higher level of reimbursement. Read the attached instructions carefully and fill out all required information. Please return the completed IEF back to our center as soon as possible.

If a member of the family (child or adult) receives Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) or Food Distribution Program on Indian Reservations (FDPIR) benefits or cares for a foster child(ren) that is the legal responsibility of Virginia Department of Social Services or the court, these children are eligible for meal benefits regardless of household income.

If the household income(s) is over the income guidelines listed below, the family is not required to complete this application. Instead, please write the child's name on the IEF and return it to our center. Please notify us if someone in the household becomes unemployed and the loss of income causes the household income to be within the income eligibility standards.

The information provided on the IEF will be used to determine the child's eligibility for meal benefits. The information will be kept confidential and only available to staff directly connected with administering the CACFP.

Family Access to Medical Insurance Security Plan (FAMIS)

FAMIS is Virginia's health insurance program for children. It provides access to quality health services for children who do not have health insurance. ***FAMIS Plus*** is Virginia's name for children's Medicaid. ***FAMIS Plus*** also provides great benefits and covers children in families with low or no income, even if the children are covered by health insurance.

By signing the section of the application for *FAMIS* or *FAMIS Plus*, the family is stating they do not want information shared with the local Department of Social Services. If IEF information is disclosed, it may be used to identify the child(ren) for the health insurance program. More information on FAMIS is available at 1-866-873-2647 – interpreters are available. Log onto www.famis.org to apply online.

A household with income less than or equal to the income chart for reduced price meals below is eligible for free or reduced-priced meals:

Household Size	Yearly
1	$23,107
2	$31,284
3	$39,461
4	$47,638
5	$55,815
6	$63,992
7	$72,169
8	$80,346
Each additional person:	$8,177

Please contact our center with any questions or for additional help.

In accordance with the 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, religion, political beliefs, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

VIRGINIA CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS and FAMILY DAY HOMES

1 All Household Members

	NAMES OF ALL HOUSEHOLD MEMBERS [Adults and Children] First, Middle Initial, Last	Check if NO income	Ages of children in care	2 FOSTER CHILD Skip to Part 6 if all are foster children.	3 SNAP, TANF or FDPIR CASE # Skip to Part 6 if you list a SNAP, TANF or FDPIR case number. SNAP and TANF MUST BE NINE (9) DIGITS
1		☐		☐	
2		☐		☐	
3		☐		☐	
4		☐		☐	
5		☐		☐	
6		☐		☐	

4 Homeless, Migrant, or Runaway

☐ Homeless ☐ Migrant ☐ Runaway

If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call your School Homeless Liaison, Migrant Coordinator.

5 Total Household Gross Income (before deductions). You must tell us how much and how often.

NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	GROSS INCOME AND HOW OFTEN IT IS RECEIVED (Example: $100/month, $100/twice a month, $100/every other week, $100/week)							
	Earnings From Work		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Comp, Unemployment, SSI, etc.	
	Amount	How often?	Amount	How often?	Amount	How often?	Amount	How often?
i.	$		$		$		$	
ii.	$		$		$		$	
iii.	$		$		$		$	
iv.	$		$		$		$	
v.	$		$		$		$	

6 Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Part 5 is completed or if zero income is listed, 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.

X X X – X X – ___ ___ ___ ___

Social Security Number

☐ **I do not have a social security number.**

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.

Date | *Printed Name of Adult Household Member* | *Signature of Adult Household Member*

7 Contact Information (Optional)

Work Telephone Number (Include Area Code) | *Home Telephone Number (Include Area Code)* | *Home Address (Number, Street, City, State, Zip Code)*

8 Optional - Sharing Information with Virginia's Health Insurance Program for Children (FAMIS)

May we share your information on this application with the *FAMIS* , the complete health insurance program for every child in Virginia? If **yes**, do not sign below.

☐ No, I do not want my information from this application shared with the FAMIS.

Date: _____ Sign here: _____

CHILD CARE REPRESENTATIVE USE ONLY – ELIGIBILITY DETERMINATION – COMPLETE SECTIONS A and B BELOW

SECTION A

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

Convert income only if different frequencies of pay are reported.

TOTAL INCOME Per $_____ ☐ Week ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year **NUMBER IN HOUSEHOLD:** _____

☐ **FREE** based on:			☐ **REDUCED** based	☐ **DENIED** reason:	
☐ foster child	☐ migrant	☐ SNAP or TANF	☐ household income	☐ income too high	☐ incomplete application
☐ homeless	☐ runaway	☐ household income		☐ non-qualifying SNAP/TANF	

SECTION B **Signature of Determining Official:** _____ **Date:** _____

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 your child for free or reduced-price meals. You must include the last four digits of your 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 or other FDPIR identifier for your child 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 your child is eligible for free or reduced-price meals, and for administration and enforcement of the Child and Adult Care Food Program. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

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, 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.

Revised July 2017; Previous Versions Obsolete

VIRGINIA WIC PROGRAM

Building a brighter, healthier future for Virginia families

WIC Offers:

- **Healthy Pregnancies**
  Prenatal education and healthy foods

- **Breastfeeding Support**
  - Lactation classes
  - Peer groups
  - Breastfeeding support hotlines
  - Breast pumps

- **Nutrition Education**
  with Registered Dietitians (RDs)

- **Healthy Foods**
  - Milk
  - Whole Grains
  - Cereal
  - Cheese
  - Yogurt
  - Juice
  - Eggs
  - Beans
  - Peanut Butter
  - Fruits and Vegetables
  - Baby Food and Cereal
  - Formula

- **Referrals**
  WIC serves as a gateway to healthcare and connects families to resources

To Enroll:

- **Apply on behalf of a child under 5 years of age if you are a:**
  - Father
  - Mother
  - Foster Parent
  - Legal Guardian

- **Apply if you are:**
  - Pregnant
  - Breastfeeding
  - Have a baby up to 6 months old

WIC has higher income guidelines than SNAP (EBT, Food Stamps) or Medicaid

1-888-942-3663

WICVA.com

VDH VIRGINIA DEPARTMENT OF HEALTH

Wholesome Informed Choices WIC Virginia Women, Infants & Children

This institution is an equal opportunity provider.

WIC 54E/S WIC 31|1-2018