New Enrollment and Re-Enrollment Packet Checklist

Item	Yes	No
New Beginnings Preschool and Child Care Enrollment Forms		
Getting better acquainted with your child.		
New Beginnings Financial Agreement		
Bank Transfer and Credit Card usage agreement		
Hours of Operation		
Discipline Policy		
Nondiscrimination Statement		
New Beginnings Preschool and Child Care Health Policy		
Field Trip Permission form		
Permission for use of preventative products		
New Beginnings Preschool Media Release Form		
Door Codes and Emails		
New Beginnings Program Contract		
Emergency Care Policy		
Parent Handbook Acceptance Agreement		
Health care record		
Record of Medication Order		
Breast Milk Procedure		
Feeding plan guidelines for infants		
Permission for center cameras		
Licensed child care home consent		
Building for the future flyer		
Income Eligibility instructions letter		
CACFP Child enrollment form		
CACFP income eligibility		
CACFP Ethnicity/ racial data		

New Beginnings Preschool and Child Care Enrollment Form

How did you hear about us? (Circle one) Sign, word of mouth, newspaper, website or current family, if you heard about us from a current family, who? _____ Enrollment Date: _____

Child's full name: _____ Date of birth: _____/_____/_____

Gender: _____ Date complete: _____/_____/_____

Child lives with: _____

If applicable, legal custody has been awarded to: _____

Parent Information

Mother: _____ Father: _____

Address: _____ Address: _____

City/State/Zip: _____ City/State/Zip: _____

Phone: _____ Phone: _____

Marital Status: _____ DOB _____ Marital Status: _____ DOB _____

Employer: _____ Employer: _____

Employer's Phone: _____ Employer's Phone: _____

Authorization for Pick-Up

Please list names, addresses and telephone numbers of people who are allowed to pick-up your child from the Center and/or will assume responsibility for you in the event of illness or emergency.

Name: _____ Address: _____

Phone: _____ _____

Name: _____ Address: _____

Phone: _____ _____

Name: _____ Address: _____

Phone: _____ _____

Child's Physician

Name: _____ Address: _____

Phone: _____ _____

Child's Dentist

Name: _____ Address: _____

Phone: _____ _____

I here by grant permission for New Beginnings Child Care to call persons on my child's emergency contact list and/or transport my child to a local hospital for emergency treatment is serious injury occurs. (Goshen, Parkview or KCH). I expect that all effort will be made to locate me or a designated person before any action will be taken. If this is not possible, I agree to accept responsibility for any expense incurred in so treating my child. I authorize first aid/ CPR to be performed by New Beginnings staff if required. I understand that the center is NOT responsible for any children who are not taken to a staff member upon arrival.

I have thoroughly read my child's enrollment form and verified that all information is current and correct. If information contained within this form becomes invalid or changes, I will notify New Beginnings Preschool and Childcare within seven (7) business days.

Parent/Guardians Signature: _____ Date: _____

Authorized Representative Signature: _____ Date: _____

Getting better acquainted with your child.

What is your child's full name? _____.

Does your child go by any other name? _____.

Why did you choose this name for your child? _____.

Does your child have siblings? _____.

Who are the important people in your child's life? _____

_____.

Does your family have any special traditions related to your beliefs, family or culture you would like us to know about?

_____

_____

Do you have pets? _____

What does your child enjoy doing? _____

What time does your child go to sleep? _____ and get up? _____

Does your child take naps? _____ If so, how long? _____

Does your child have any special routines or items they sleep with? _____

_____

What are meal and snack times in your home? _____

_____

Does your child need assistance feeding themselves? _____

Does your child use a fork and a spoon? _____

Does your child drink from an open-faced cup? _____

Does your child take regular medications? If so, will they need administered here? _____

_____

Does your child have any health concerns that we need to be aware of? If so, please explain. _____

_____

Does your child interact socially? _____

Does your child have any learning or physical limitations? _____

_____

Does your child have any special needs or fears? _____

Is there anything you would like us to know about your child? _____

_____

New Beginnings Financial Agreement

A. Child tuition payment is due the Monday of the week your child is attending. You have until 5:30 PM on Wednesday before a $20 late fee is charged to your account. These are based on your written contract, space fee and the number of children you have in your family that are also attending New Beginnings. If the center is not open on Monday, the fees are due on Tuesday. Failure to pay means that the fees are considered in default.

B. If your child remains in the custody and care of New Beginnings Preschool and Child Care after 5:30 PM, the director or staff member in charge of the center at the time shall attempt to contact each individual listed as emergency contacts on your child's enrollment information sheet completed at the time of registration. The center reserves the right to charge a $20 fee, per child if you are five minutes late. After 30 minutes Milford police will be contacted as well as Child Protective Services (470 IAC 3-4.1-6(b)).

C. If your child is not signed in or out on the attendance book in the lobby, you will be charged a $5 fee.

D. If you are on the Brightpoints voucher program or On My Way Pre K and your child is not signed in or out on the voucher machine, you will be charged $5 each day they are not signed in or out. This charge will be due at the end of the current week and only cash will be accepted.

E. The center request to be notified before 8:30 AM if your child will not be in attendance that day. If the center is not contacted by 8:30 AM the day of your child's absence, you will be charged a fee of $15.

F. A nonrefundable enrollment fee of $60 is required prior to your child starting the program. This fee covers the administration costs associated with processing your child's enrollment information. A yearly re-enrollment fee and update enrollment forms are due every year in August. The re-enrollment fee is $60 per family.

G. Families are required to give us two weeks' notice if they are discontinuing our services for their child/children. Failure to do so will result in you being charged and responsible for you paying the following two weeks of your child's weekly fees.

H. No child shall be accepted into the center on any day if their fee is in default. Correcting the default requires that all past due fees are paid, including any late fees incurred.

I. if one or more of the individuals signing this agreement are in default, the senator may bring civil action against this person. This action may include, but is not limited to collection of the following:
    a. The fees in default
    b. Interest on balance due
    c. Collection costs
    d. Reasonable attorney fees
    e. All other costs of reasonable collection

J. Any fees entering default will incur a late charge of $20. Any fee in default for a period of more than seven days shall earn interest at the rate of $20 a week, unless other arrangements have been made. These arrangements are at the discretion of the executive director.

K. There will be a $30 charge on all return checks.

L. There will be a $15 charge for all failed bank transfers or credit card payments.

M. If your child does not attend the Center for a period of two weeks, and we are not notified, the child will be dropped from enrollment.

Parent/Guardian Signature: _____ Date: _____

Authorized Representative Signature: _____ Date: _____

Bank transfer and credit card usage agreement.

New Beginnings offers bank transfers and credit card payments to pay child care fees through our hiMama app.

For bank transfers:

You are able to link your bank debit card information through the app. You may set it up to autopay if you choose. There is no processing fee for this option.

For credit cards:

if you opt for this method of payment, you will enter all your credit card information on your hiMama account. **There is a 2.9% processing fee per transaction** from the credit card companies that we are charged for. This fee will be charged back to you on the last Monday of the month and is due by that Friday.

In the event a bank transfer or credit card payment fails there is a $15 charge.

Any questions or concerns should be directed to the executive director.

Parent/Guardian's Signature: _____ Date: _____

Authorized Representative Signature: _____ Date: _____

Hours of Operation.

New Beginnings is licensed to operate between the hours of 5:30 AM and 5:30 PM Monday through Friday. The center reserves the right to charge a $20 fee, per child, if you are five minutes late picking up your child. After 30 minutes, the Milford police will be contacted as well as Child Protective Services (470 IAC 3-4.1-6(b)).

My child/with children will attend new beginnings according to the following schedule days and times circle below:

Monday Tuesday Wednesday Thursday Friday

My child will be dropped off at _____ and picked up at _____.

This schedule is documented on your child's financial contract, along with the days and times your child will be attending the center. If your child's schedule will change due to a doctor's appointment or other scheduled appointment, we ask, when possible, that you give the center one weeks' notice.

If your child's entire schedule needs to change due to your job, family situation or any other unforeseen issue, we ask that you give us a two-week notice. This ensures that we are meeting the developmental needs of the children in our care and that teacher to child ratios are maintained.

If a two-week notice is not given you will be charged $60 for the change in schedule to cover staffing costs.

If your child needs to be picked up later or dropped off earlier thank your current schedule states during the week, you must give us a 24-hour notice and you will be charged $40.00. Otherwise, we will be unable to provide care for you at that time.

Meals and snacks

Breakfast will be offered to children in attendance at 9:30 AM. Lunch will be served to those in attendance at 11:30 AM. AM snack will be served at 7:30 AM and PM snack is served at 2:30.

Discipline Policy

The executive director shall not use or permit any person to use corporal, cruel, harsh, unusual punishment or any humiliating or frightening punishments to control the actions of any child or group of children. No child shall ever be shaken, hit or spanked. Brief supervised separation from the group may be used if necessary.

I have read and discussed the discipline policy and understand that any disciplinary actions taken place will be reported to the parent and noted in the child's file.

Parent/Guardian's Signature: _____ Date: _____

Authorized Representative: _____ Date: _____

Nondiscrimination 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, employees and institutions participating in or administering USDA programs are prohibited from discrimination based on race, color, national origin, sex, disability, age, or reprisals or retaliation for prior civil rights activity in any program or activity conducted or funded by the USDA.

persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, ASL, 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 the 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 the 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 the USDA by:

1) Mail: U S Department of Agriculture

   Office of the assistant secretary for civil rights

   1400 Independence Ave, 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.

I have read the above nondiscrimination statement and I understand my rights.

Parent/Guardian Signature: _____ Date: _____

Authorized Representative Signature: _____ Date: _____

New Beginnings Preschool and Child Care Health Policy

Children who are ill upon arrival shall not be admitted for care, both for their own well-being as well as for the well-being of others. A child should be kept home when any of the following symptoms are in evidence: contagious disease, nausea, vomiting, diarrhea, fever over 100.6 or an undiagnosed rash. **Your child will not be admitted to the center until they have been symptom free for 24 hours.** This is to decrease the sharing of illness between children and to keep our Center as healthy as possible. If your child becomes ill while at the Center, you will be notified and be required to pick up your child as soon as possible. If a parent refuses to pick up a child after notification of illness, the child may be terminated from the program. Any exception from this policy will require a note from the child's physician permitting them to be at preschool.

I have read and understand the above policy. I agree to the following policy in the event that my child may become sick.

Parent/Guardian Signature: _____ Date: _____

Authorized Representatives Signature: _____ Date: _____

Walking Field Trips

At New Beginnings Preschool, we enjoy spending time outdoors. On special occasions your child's teacher(s) may take their class on a short walking field trip. For example, the children enjoy walking over to the Milford Elementary track to ride bikes or explore the small, wooded area. By signing this permission slip, you are allowing your child to leave the perimeter of the Center with their teacher.

I, _____ (parent/guardian), give permission for

_____ (child's name) to go on walking field trips with staff members of New Beginnings Preschool and Child Care Staff.

Parent/Guardian Signature: _____ Date: _____

Authorized Representative Signature: _____ Date: _____

Permission for Use of Preventative Products

I, _____, give New Beginnings permission to administer

_____(sunscreen name) and _____ (name of bug spray to _____(child's Name) as needed while outside.

Parent/Guardian Name: _____ Date: _____

Authorized Representative Signature: _____ Date: _____

New Beginnings Preschool Media Release Form

I, _____ give permission for New Beginnings Preschool and Child Care, INC to use the image of my child, _____ as initialed below. The center may obtain my child's image by use of photographs or video used in materials that include, but are not limited to; the centers newsletters, postings put up in the center, local newspaper, advertisements in the community, the centers website or the center's Facebook page.

_____ I deny permission for any uses of my child's image

_____ I grant unrestricted usage for any use of my child's image. I agree that these images or videos may be used by the center for a variety of purposes and that they may be used without further notifying me.

In the event that I no longer with for my child's image to be used by the center, I will notify the Curriculum Coordinator or Executive Director in writing to discontinue use of my child's image.

Parent/Guardian Signature: _____ Date: _____

Authorized Representative Signature: _____ Date: _____

If you are interested in receiving our newsletter and parent information by email, please fill out the bottom section of this letter and return it to the office. If you choose not to receive emails please pay special attention to the postings at the Center for upcoming events and notices. We hope this will help parents see information faster and easier. If you have any questions or concerns please feel free to contact the center's executive director or curriculum coordinator.

We also ask that you give us a four-digit number code to use to enter the building. Please pick a code that is easy to remember and please keep it confidential. Everyone on your authorization pickup list will need a code.

Name: _____ Code: _____

Name: _____ Code: _____

Name: _____ Code: _____

Name: _____ Code: _____

I would like to start receiving parent information via email from the center.

Name: _____

E-Mail: _____

Name: _____

E-mail: _____

New Beginnings Preschool and Child Care Program Contract

My child/children _____, will be scheduled to attend New Beginnings Preschool and Childcare's full-time program at the rate of _____, per session _____per week. I am allowed _____ vacation days. My payment is due as scheduled for the contracted amount. For each vacation day used, _____ will be deducted from my weekly amount owed. Vacations may not be used for holidays.

This contract will be updated every year in August and may be changed for the following reasons:

Change in employment, change it in family situation or changes in work schedules.

Parent/Guardian Signature: _____ Date: _____

Authorized Representative Signature: _____ Date: _____

New Beginnings Preschool and Child Care Permission for Emergency Care Policy

I, _____, Parent/Guardian of _____,

Grant New Beginnings Preschool and Child Care permission to provide care for my child in the event of medical emergencies. If transport and treatment are required, I fully understand that New Beginnings Preschool and Child Care will not be held accountable for fees incurred in transporting and treatment of my child.

In the event of an emergency, an employee of the center shall call as soon as possible. EMT is usually transport to Goshen Hospital or St. Joe, however, transportation may be diverted to Kosciusko Community Hospital or Parkview in Warsaw, depending on emergency availability and serious nature of the injury. This information will be provided to the parent as soon as we are given the information.

I fully understand and agree to the terms of the policy set forth by New Beginnings Preschool and Child Care.

Parent/Guardian Signature: _____ Date: _____

Authorized Representative Signature: _____ Date: _____

New Beginnings Preschool and Child Care

706 W. Syracuse St.

Milford IN 46542

Phone: 574-658-9440 fax: 574-658-5512

newbeginningspreschool@centurylink.net

Parent handbook acceptance agreement.

I, _____ hereby certify that I have carefully and thoroughly read, understand and accept those policies and procedures pertaining to my area of responsibility.

Parent/Guardian Signature: _____ Date: _____

Authorized Representative Signature: _____ Date: _____

HEALTH CARE PROGRAM FOR CHILD CARE
HEALTH RECORD - CHILD

State Form 49969 (R5 / 7-19)

FAMILY AND SOCIAL SERVICES ADMINISTRATION - MS02
402 W. Washington St., Room W362
Indianapolis, IN 46204

Name of child (*last, first*)	Date of birth (*month, day, year*)	Date of admission (*month, day, year*)
Address (*number and street, city, state, and ZIP code*)		
Child lives with (*relationship*)	Name	Telephone number ( )

MEDICAL HISTORY

Communicable Disease	Month / Year	Condition	Explain if present
		Allergies:	
		Handicapping conditions:	
Screenings	**Result / Date** (*month, day, year*)		
TB Risk / Symptom		Other:	
Developmental Screen			
Lead			

PHYSICAL EXAMINATION

Date of exam (*month, day, year*)	Age of child
Skin	Heart
Lymphnodes	Lungs
Eyes	Abdomen
Ears	Genitalia
Nasopharynx	Skeleton
Teeth and Mouth	Other:

Note any unusual findings:

Does this child have any health condition that would be hazardous either to the child or to other children in a group setting as a result of participation in normal activities (*including sports*)?

☐ Yes ☐ No If Yes, what modification of normal activities would be necessary to protect the child and the child's classmates:

Have you prescribed any medications or special routines which should be included in the center's plans for this child's activities? Explain:

☐ Yes ☐ No

(*Over*)

RECORD OF MEDICATION ORDER

State Form 49968 (R3 / 2-15)

FSSA - MS02
402 WEST WASHINGTON STREET, RM W361
INDIANAPOLIS, IN 46204

All medications, medicinal products, physician's sample medications, and medicinal skin care products given or used at a child care center must include the exact name of medication, dosage to be given, time to be given and reason for use. (*If used for fever, the degree of temperature must be stated.*) A prescriber order is valid for one (1) year.

1. Name of child	Exact name of medication
Dosage to be given	Time to be given (*frequency*)
Reason for use:	
Signature of physician / nurse practitioner	Date (*month, day, year*)

2. Name of child	Exact name of medication
Dosage to be given	Time to be given (*frequency*)
Reason for use:	
Signature of physician / nurse practitioner	Date (*month, day, year*)

3. Name of child	Exact name of medication
Dosage to be given	Time to be given (*frequency*)
Reason for use:	
Signature of physician / nurse practitioner	Date (*month, day, year*)

4. Name of child	Exact name of medication
Dosage to be given	Time to be given (*frequency*)
Reason for use:	
Signature of physician / nurse practitioner	Date (*month, day, year*)

5. Name of child	Exact name of medication
Dosage to be given	Time to be given (*frequency*)
Reason for use:	
Signature of physician / nurse practitioner	Date (*month, day, year*)

HISTORY OF IMMUNIZATIONS AND TEST (*indicate month / day / year*)

	1	2	3	4	5
DTaP / DT					

	1	2	3	4
Hib				

	1	2	3	4	5
IPV (Polio)					

	1	2	3	4	5
* Influenza (Flu)					

	1	2
Measles Mumps Rubella (MMR)		

	1	2	3
Rotavirus (RGE)			

	1	2		
Varicella (Varivax)			or Chicken Pox Disease	Month / year

	1	2	3	4
Pneumococcal (PCV) (Prevnar)				

	1	2
HEP A		

	1	2	3
HBV (HEP B)			

* Recommended yearly.

Name of physician / nurse practitioner / physician assistant completing form (*please print*)	Telephone number ( )
Signature of physician / nurse practitioner / physician assistant	

ADDITIONAL NOTES AND INSTRUCTIONS

BREAST MILK PROCEDURE

State Form 49954 (R6 / 12-21)

FSSA - MS02
402 WEST WASHINGTON STREET, RM W362
INDIANAPOLIS, IN 46204

Breast milk is a very special product. Provide a safe and excellent source of nutrition to your breast-fed infants by following the procedure below:

1. The facility or the mother must supply sterilized bottles or disposable nurser bags (*see "Parent Agreement"*).

2. The mother will store her milk in a bottle or bag and refrigerate or freeze the milk. The bottle or bag should contain no more than the amount of milk the child would drink at one feeding. The milk must be labeled with the child's name and the date and time collected.

3. The bottles or disposable bags must be brought to the center in a clean, insulated container which keeps the milk at 41° F or below (*see "Parent Agreement"*).

4. Fresh, refrigerated breast milk must be used within forty-eight (48) hours of the time expressed. Frozen milk may be stored in a refrigerator freezer for three (3) to six (6) months or stored in a deep freezer at -4° F for six (6) to twelve (12) months.

5. Frozen breast milk may be thawed as follows:

   (a) Frozen breast milk may be thawed under warm water, gently swirled, used within one (1) hour or refrigerated immediately and used within twenty-four (24) hours. Label the bottle with the time and date thawed and method used for thawing (*"warm water" or "heat thaw"*).

   (b) Frozen breast milk may be thawed in the refrigerator at 41° F or below. Label the bottle with the time and date moved to the refrigerator and "cold thaw" method and use within twenty-four (24) hours. With this method, **never warm** the breast milk until ready to feed the child.

   (c) Do not refreeze the breast milk once it has been thawed.

NEVER HEAT BREAST MILK IN A MICROWAVE!

Note: Once a bottle is fed to infant, the remainder **must be discarded** and cannot be returned to the refrigerator.

PARENT AGREEMENT

I, _____, agree to provide my breast milk for my child _____ in sterilized bottles or sterile nurser bags. I will store my milk in the appropriate serving size for my child. I take full responsibility for maintaining this milk at 41° F or below during home storage and transport to the center.

Signature of parent	Date (*month, day, year*)

SUPPLEMENTAL HEALTH CARE PROGRAM FOR CHILD CARE CENTERS PROVIDING INFANT-TODDLER CARE SUGGESTED FEEDING PLAN

State Form 49963 (R4 / 12-21)

FSSA - MS02
402 WEST WASHINGTON STREET, RM W362
INDIANAPOLIS, IN 46204

INSTRUCTIONS:

Prior to admission, a feeding plan shall be established and written for each infant (age six (6) weeks to twelve (12) months) in consultation with the parents and based on the written recommendation of the child's medical provider. Feeding plans must be continually updated by the child's medical provider or parent. [470 IAC 3-4.7 (b)]

The following feeding plan has been recommended for this child.

Name of child	Date of birth (*month, day, year*)

Age in Months	Time to Feed	Formula / Food Item and Amount	Special Instructions	Signature and Date of Parent or Medical Provider

Signature of MD, DO, NP, PA	Date signed (*month, day, year*)

FEEDING PLAN GUIDELINES

INSTRUCTIONS: This is a guideline. Each child will grow at a different rate.

1. *Formula, breast milk, water or juice may be offered in a training cup when a child is ready.*
2. *Formula or breast milk is used until twelve (12) months unless otherwise stated by a physician.*
3. *Only plain, strained, mashed or chopped vegetables, fruits and meats are offered.*
4. *Most children are ready for foods of coarser consistency between nine (9) to ten (10) months of age. Mashed or chopped table foods may be used.*
5. *Strained or mashed foods may be introduced at six (6) months if the infant's neuromuscular system has developed appropriately. Indications for solid foods are: the ability to swallow non-liquid foods, to sit with support, head and neck control, and to show that the child is able to decline food by leaning back or turning away.*
6. *Finger foods may be offered between nine (9) to twelve (12) months when infant is developing finger / hand coordination.*
7. *The serving of juice to children under twelve (12) months of age is discouraged.*

2 MONTHS - 5 MONTHS				
TIME INTERVAL	**AMOUNT EACH FEEDING**			
	Month 2	Month 3	Month 4	Month 5
6:00 a.m.	4 - 6 oz.	4 - 7 oz.	5 - 7 oz.	5 - 8 oz.
10:00 a.m.	4 - 6 oz.	4 - 7 oz.	5 - 7 oz.	5 - 8 oz.
2:00 p.m.	4 - 6 oz.	4 - 7 oz.	5 - 7 oz.	5 - 8 oz.
6:00 p.m.	4 - 6 oz.	4 - 7 oz.	5 - 7 oz.	5 - 8 oz.
10:00 p.m.	4 - 6 oz.	4 - 7 oz.	5 - 7 oz.	5 - 8 oz.
2:00 a.m.	4 - 6 oz.	4 - 7 oz.	5 - 7 oz.	5 - 8 oz.

6 MONTHS - 12 MONTHS					
	Month 6	Month 7	Month 8	Month 9	Months 10, 11, and 12
Total Amount of Formula Per 24 Hours	30 - 48 oz.	30 - 32 oz.	29 - 31 oz.	26 - 31 oz.	24 - 32 oz.
7:00 a.m.	5 - 8 oz. formula 2 - 3T baby cereal *	6 oz. formula 2 - 3T baby cereal *	7 - 8 oz. formula 3 - 5T baby cereal *	7 - 8 oz. formula ** 4 - 6T baby cereal * 2 - 4T fruit	6 - 8 oz. formula ** (*1cup*) 1/4 - 1/2 baby cereal * 2 - 4T fruit
9:00 a.m.	5 - 8 oz. formula	6 oz. formula	1/2 cup Vitamin C fortified fruit or juice 1/4 dry toast or 1 cracker	1/2 cup Vitamin C fortified fruit or juice 1/2 dry toast or 2 crackers	1/2 cup Vitamin C fortified fruit or juice 1/2 dry toast or 2 crackers
12:00 Noon	5 - 8 oz. formula 1/2 dry toast or 2 crackers	6 oz. formula 2 - 3T strained vegetable	7 - 8 oz. formula 5 - 9T vegetable 2 - 4T fruit	7 - 8 oz. formula ** 1 - 2T meat 5 - 9T vegetable 2 - 4T fruit	6 - 8 oz. formula ** (*1 cup*) 2T meat 2 - 6T potato, rice, noodles 5 - 9T vegetable 4 - 6T fruit
3:00 p.m.	5 - 8 oz. formula	6 oz. formula 1/2 dry toast or 2 crackers	7 - 8 oz. formula 1/2 dry toast or 2 crackers	7 - 8 oz. formula ** 1/2 dry toast or 2 crackers	6 - 8 oz. formula ** (*1 cup*) 1/2 dry toast or 2 crackers
6:00 p.m.	5 - 8 oz. formula 2 - 3T baby cereal *	6 oz. formula 2 - 3T strained fruit 2 - 3T baby cereal *	7 - 8 oz. formula 5 - 9T vegetable 2 - 4T fruit 2 - 5T baby cereal *	7 - 8 oz. formula ** 5 - 9T vegetable 2 - 4T fruit 1T meat 4T baby cereal *	6 - 8 oz. formula ** (*1 cup*) 2T meat 2 - 6T potato, rice, noodles 2 - 4T vegetable 2 - 4T fruit
9:00 p.m.	5 - 8 oz. formula	May start sleeping through the night.			

* If dry cereal is used, mix cereal and formula in a bowl. Feed with a spoon.
** Formula may be offered in a training cup.

Dear Parents and Guardians,

We are taking this opportunity to inform you that we will be installing cameras in our lobby area and the classrooms. These cameras will be used to help obtain authentic observations of staff and children for developmental progress, be used as an extra set of eyes in the classroom should something happen when a teacher is busy with other students and to view how curriculum is being implemented in the classrooms.

Privacy is of the utmost importance at New Beginnings so, the only staff members who will have access to the footage will be the Board of Directors, the Executive Director and our Curriculum Coordinator.

If an incident arises and a parent requests footage be viewed, it will first be viewed by our Board President to ensure the privacy and confidentiality of all parties is respected.

Attached you will find a permission form acknowledging your understanding and acceptance of the use of cameras in your child's classroom.

If you have any concerns or questions, please contact myself or Kristin Billet.

Sincerely,

Jana Sexton

Curriculum Coordinator

Permission for Center Cameras

I, _____, give New Beginnings Preschool and Child Care permission for the use of cameras in my child, _____, classroom.

I understand that footage will be kept in the strongest of confidence and will not be shared with other parties pertaining to my child.

Parent's Signature: _____ Date: _____

Authorized Representative : _____ Date: _____

LICENSED CHILD CARE CENTER / HOME CONSENT

State Form 50548 (R2 / 7-06) / BCC 0080

To: Parents of licensed child care programs in Indiana

Subject: Your child's birth certificate and licensed child care programs

Indiana Code 12-17.2-2-1(8) requires each child care center or child care home to record proof of a child's date of birth before accepting the child for care. A child's date of birth may be proven by the child's original birth certificate or other reliable proof of the child's date of birth, including a duly attested transcript of a birth certificate. Refusing to share this information may result in your child's exclusion from a licensed child care program. Sharing the birth certificate information is NOT optional; signing the below is your decision and does not impact your use of child care facilities.

tear here

LICENSED CHILD CARE CENTER / HOME CONSENT

State Form 50548 (R2 / 4-06) / BCC 0080

This portion is to be kept on file at the licensed child care program.

I give my permission for New Beginnings Preschool and Child Care INC. (*name of licensed child care program*) to report the name and date of birth of my child or children to the Division of Family Resources pursuant to IC 12-17.2-2-1.5.

Name of child	Date of birth (*month, day, year*)
Name of child	Date of birth (*month, day, year*)
Name of child	Date of birth (*month, day, year*)
Name of child	Date of birth (*month, day, year*)

Signature of parent, guardian, or custodian	Date signed (*month, day, year*)

Building for the Future with CACFP

This day care receives support from the Child and Adult Care Food Program to serve healthy meals to your children.

Meals served here must meet USDA's nutrition standards.

Good nutrition today means a stronger tomorrow!

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

Breakfast	Lunch or Supper	Snacks (Two of the FIVE)
Fluid Milk Fruit or Vegetable Grains or Bread Meat/Meat Alternate	Fluid Milk Meat or meat alternate Grains or bread Vegetable Fruit	Milk Meat or meat alternate Grains or bread Fruit 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

New Beginnings Preschool and Child Care
706 W. Syracuse St.
Milford Indiana 46542
(574) 658-9440

Indiana Department of Education

CACFP Staff
School & Community Nutrition
Indiana Government Center North, 9th floor
100 N Senate Ave
Indianapolis IN 46204
800-537-1142 or 317-232-0850

April 2021

CACFP Meal Benefit Income Eligibility Form Instructions

The Child and Adult Care Food Program (CACFP) makes good food a regular part of day care! Please fill out the *CACFP Meal Benefit Income Eligibility* form. It helps us find out if your household qualifies for free or reduced-price meals. This lets us know how much money CACFP will give to support your day care center.

Instructions

Here are instructions to help you fill out the form. Before you begin, turn the form over to learn why we ask for this information. It tells you how we use the information and what rights you have. It also tells you how to contact USDA if you believe you are treated unfairly.

Please make sure to fill in all of the requested information. Use a pen to mark your answers on one form. When you are finished, please return the form to us at:

New Beginnings Preschool and Childcare, 706 W. Syracuse Milford IN., 46542

Step 1:

List everyone from your household attending the day care. Use one line for each person's name. Write one letter in each box. Stop if you run out of space. If there are more than five people, add their names on a second piece of paper.

Do you have any foster children? If you answer *Yes*, mark the *Foster Child* box next to the child's name. If you are only applying for foster children, finish Step 1 and go to Step 4. If you are applying for both foster and non-foster children, go to Step 2.

Are any children migrant, runaway, homeless, or enrolled in Head Start? If *Yes,* mark the correct boxes next to the child's name and go to Step 4.

Step 2:

For Childcare: You qualify for free meals if you live in a household that receives Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR).

For Adult Daycare: You qualify for free meals if you live in a household that receives Supplemental Nutrition Assistance Program (SNAP), Food Distribution Program on Indian Reservations (FDPIR), Supplemental Security Income (SSI), or Medicaid benefits.

Do any household members, including you, currently receive these benefits? If *Yes*, write the case number in the box and go to Step 4. You only need to provide one case number. If *No*, go to Step 3.

Step 3:

Report current income for all household members. Skip this step if you answered Yes in Step 2.

How do you report child income? Turn the form over and use the *Source of Income for Children* chart to see if your household has income to report. Write the amount in the boxes in part A of the form. Mark how often the amount is earned. Write *0* in the box if there is no income to report.

How do you report income of adult household members? Turn the form over and use the *Source of Income for Adults* chart to see if your household has income to report.

In part B, list the adults in your household, including you, even if each of you doesn't receive income. Include adults, such as grandparents, other relatives, and friends who live with you and share household income and expenses. Write the amount of income each of you receives, in the boxes next to your names. Mark how often the amount is received. Write *0* in the box if there is no income to report.

Make sure you report the current amount of money you get before taxes. Don't include SNAP, FDPIR, WIC, student financial aid, or money you receive for a foster child as income.

Count the number of all children and adults in your household. Include all infants, children, students, and adults. Write the total number in the box under the list of adult household members.

Do you or another adult household member have a Social Security number? Write the last four digits in the boxes. If there is no Social Security number, mark the *Check if no SSN* box.

Points to Remember:

If:	**Then:**

Your income isn't always the same	**List the amount of money that you normally get. For example, don't include overtime pay, if you don't normally get it. If your income is normally higher or lower, you can report annual income instead.**
Your household includes members who aren't citizens	**Participants don't have to be U.S. citizens to qualify for meal benefits.**
You are in the military	**Don't include your Family Subsistence Supplemental Allowance (FSSA), combat pay, or the money you receive for privatized housing. If deployed, count any pay that is provided to your household as income.**

Step 4:

An adult household member must sign this form. The signer promises that all information is true and complete.

Print the name, address, and telephone or email of the adult signer. Sign and write today's date in the marked boxes.

Optional: We ask about the participants' ethnicity and race to make sure we do our best to serve our community. Providing this information is not required. You won't be denied benefits based on your race, color, national origin, sex, age, or disability

CACFP Meal Benefit Income Eligibility Form
Letter to Household (Non-Pricing Centers)

Dear Households:

New Beginnings Preschool and Childcare offers healthy meals and snacks to everyone in care as part of the Child and Adult Care Food Program (CACFP). New Beginnings Preschool and Childcare receives support from CACFP to serve those meals. CACFP gives more support if your household income is less than or equal to the limits on this chart:

Federal Income Standards for Reduced-Price Meals for July 1, 2023 - June 30, 2024		
Household size	Yearly Income	Monthly Income

This institution is an equal opportunity provider.

1	26,973	2,248
2	36,482	3,041
3	45,991	3,833
4	55,500	4,625
5	65,009	5,418

Please fill out a *CACFP Meal Benefit Income Eligibility* form. It will help us find out how much support New Beginnings Preschool and Childcare receives. Please be sure to read the instructions carefully. Fill in all the information we request. We can only accept complete forms. Please submit the completed form to:

New Beginnings Preschool and Childcare

706 W. Syracuse St.

Milford, IN 46542

director@newbeginningsforkids.org

Thank you for taking the time to fill out the form.

In the operation of child nutrition programs, no person will be discriminated against because of race, color, national origin, sex, age, or disability. If you have questions or need help, please contact Jana Sexton, 574-658-9440 or director@newbeginningsforkids.org

Sincerely,

Jana L. Sexton
Interim Director
This institution is an equal opportunity provider.

CHILD ENROLLMENT FORM

IDOE/CACFP
June 2019

Name of Institution: New Beginnings Preschool and Child Care INC. Sponsor ID Number:1430150
Name of Facility: New Beginnings Preschool and Child Care INC.

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: Parents Choice Gentle
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:

This institution is an equal opportunity provider.

CACFP Meal Benefit Income Eligibility

Complete one application per household. Please use a pen (not a pencil).

APPLY ONLINE:
Insert URL Here

STEP 1 List ALL children or adults in day care (if more spaces are required for additional names, attach another sheet of paper)

Children in Foster care and children who meet the definition of **Homeless, Migrant** or **Runaway** are eligible for free meals.

Children in **Head Start** are eligible for free meals if an approved head start application or statement of enrollment is attached.

Participant's First Name	MI	Participant's Last Name	Check all that apply: Foster Child	Migrant	Runaway	Homeless	Head Start
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐

STEP 2 List the following assistance programs any household member participates in - for child care: SNAP, TANF, or FDPIR, or for adult daycare: SNAP, FDPIR, SSI, or Medicaid

IF NO > Go to STEP 3 **IF YES >** Write case number here and proceed to STEP 4 (do not complete STEP 3)

CASE NUMBER:

Write only one case number in this space.

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

The **"Sources of Income for Children"** chart will help you with the Child Income section.

The **"Sources of Income for Adults"** chart will help you with All Adult Household Members section.

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related."

A. Child Income
Sometimes children in the household earn or receive income. Please include the TOTAL income received by all child Household Members listed in STEP 1 here.

Child Income $ ____ How often? ○ Weekly ○ Bi-Weekly ○ Monthly ○ Annually

B. All Other Household Members (Including yourself)
List all adult Household Members (including yourself) as well as any children not listed in STEP 1 even if they do not receive income. For each person listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars. If they do not receive income from any source, you must write '0' - do not leave blank. If you enter '0', you are certifying that there is no income.

Name of Household Members (First and last)	Earnings from Work $	How often? ○ Weekly ○ Bi-Weekly ○ Monthly ○ Annually	Welfare/Child Support/Alimony $	How often? ○ Weekly ○ Bi-Weekly ○ Monthly ○ Annually	Pensions/Retirement/ Social Security/SSI/ VA Benefits $	How often? ○ Weekly ○ Bi-Weekly ○ Monthly ○ Annually
	$		$		$	
	$		$		$	
	$		$		$	
	$		$		$	
	$		$		$	

Total Household Members (Children and Adults) ☐☐

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or other Adult Household Member X X X X X ☐☐☐☐ Check if no SSN ☐

STEP 4 Contact information and adult signature. SUBMIT COMPLETED FORM TO THE DAY CARE AT:

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Print Name of Adult Signing the Form _____ Signature of Adult _____ Today's Date _____

Address _____ City _____ State _____ Zip _____ Phone/Email _____

Source of Income for Children	
Sources of Child Income	**Examples**
Earnings from work	• A child has a regular full or part-time job where they earn a salary or wages
Social Security - Disability Payments - Survivors Benefits	• A child is blind or disabled and receives Social Security benefits • A parent is disabled, retired, or deceased, and their child receives Social Security benefits
Income from person outside of household	• A friend or extended family member reguarly gives a child spending money
Income from any other source	• A child receives regular income from a private pension fund, annuity, or trust

Source of Income for Adults		
Earnings from Work	**Public Assistance/Alimony/ Child Support**	**Pensions/Retirement/ All other sources of income**
• Salary, wages, cash bonuses • Net income from self-employment (farm or business) **If you are in the U.S. Military:** • Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) • Allowances for off-base housing, food, and clothing	• Unemployment benefits • Workers compensation • Supplemental Security Income (SSI) • Cash assistance from State or local government • Alimony payments • Child support payments • Veterans benefits • Strike benefits	• Social Security (including railroad retirement and black lung benefits) • Private Pensions or disability benefits • Income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • Regular cash payments from outside household

OPTIONAL Participant's Ethnic and Racial Identities (Optional)

We are required to ask for information about the participant's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect eligibility for receiving meals during care.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

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 last four digits of 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 the meal reimbursement for your child care center/provider. 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.

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:

MAIL*: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

FAX: (202) 690-7442; or
EMAIL: program.intake@usda.gov.

This institution is an equal opportunity provider.

***Only use this address if you are filing a complaint of discrimination.**

DO NOT FILL OUT Sponsor use only - The Determining Official's dated signature is required

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Monthly x 12 *(required if earnings are in more than one frequency type)*

Use this space for income calculations:

Total Income

How often? Weekly ○ Bi-Weekly ○ Monthly ○ Annually ○

Household size

Categorial Eligibility ☐

Eligibility: Free ☐ Reduced ☐ Paid ☐ Tier I ☐ Tier II ☐

Determining Official's Signature (required) | Date (required) | 2nd Official's Signature | Date | 3rd Official's Signature | Date