Heather Ridge Child Care
Admission Agreement

Parent's Name: _____ Phone #: _____

Address _____ Cell #: _____

City _____ State _____ Zip _____ Email: _____

Parent's Name: _____ Phone #: _____

Address _____ Cell #: _____

City _____ State _____ Zip _____ Email: _____

Child #1 _____ Birthday _____ M T W T F Hours _____

Child #2 _____ Birthday _____ M T W T F Hours _____

Child #3 _____ Birthday _____ M T W T F Hours _____

Meals child(ren) will be eating at school ? Breakfast Y / N Lunch Y / N Snack Y / N

Parent Employer _____ Phone #: _____

Parent's Employer _____ Phone #: _____

Doctor _____ Phone #: _____

Emergency Contact _____ Phone #: _____

Emergency Contact _____ Phone #: _____

Emergency Contact _____ Phone #: _____

Emergency Contact _____ Phone #: _____

How did you hear about Heather Ridge _____

I have read the Admission Policies and agree to follow those regulations stated therein. I understand the agreement regarding fees and payment. I understand the agreement regarding arrival/departure, late fees, meals, holidays, and termination. I agree to notify the Center two weeks in advance of withdrawal or pay the difference. I understand there are no deductions or exchanges for days absent or for days missed due to illness.

Parent Signature _____ Date: _____

Director's Signature _____ Date: _____

"Heather Ridge Childcare Center is an equal opportunity provider."

Heather Ridge Child Care
820 St. Marks Street, Redding CA 96003
530-241-7226

Admission Policies

Welcome to Heather Ridge Child Care. The following policies are to assist us in providing quality Child Care. All policies are part of your contract and should be read and understood before signing. Office hours are 8:30 a.m. to 4:30 p.m.

ON YOUR CHILD'S FIRST DAY The following forms must be in the administration office:

- Admission Agreement
- Emergency Treatment Consent Form
- Information & Emergency ID form
- Parent's Rights & Personal Rights Forms
- Health History
- Copy of Child's Shot Record
- Physician's Report

All forms are subject to yearly renewal and must be kept up to date. Please inform the office of any change in information (telephone #, address, etc.).

INFANT You must furnish bottles (plastic only) disposable diapers, diaper wipes, change of clothing and a nap time blanket.

PRESCHOOLER You must furnish a change of clothing and a nap time blanket. If your child has a special sleep toy or blanket we encourage you to bring them for rest time.

ALL ITEMS MUST BE LABELED WITH YOUR CHILD'S NAME FOR EASY IDENTIFICATION

LOST ITEMS Heather Ridge Child Care is not responsible for lost items. A share toy must be shared on appropriate share days. If a child brings a toy on a day other than a share day the teacher will politely put it in the share box and the child can have it at the end of the day.

OPERATING HOURS 630 a.m. to 530 p.m. for two years and above
700 a.m. to 530 p.m. for infants, 0 – 24 months

No child will be admitted after 10:00 a.m. without prior arrangements. Initial _____

All children must arrive before 10:00 a.m. Children scheduled to be picked up at closing must be picked up promptly at 5:30 p.m. A late fee will be assessed for those children picked up after closing. The staff has been instructed to collect a $5.00 late fee between 5:31 and 5:35 p.m., and then $1.00 for every minute thereafter. If you have a family emergency the staff will be very understanding and every effort will be made to reduce the late fee. If your child is half day only you must adhere to the scheduled hours or pay for a full day.

PAYMENT OF MONTHLY TUITION You will be responsible for paying your child's monthly tuition on the 1st of each month. If you have contracted to pay twice monthly it will be due on the 1st and the 15th. A $25.00 late fee will be charged to your account on the 21st of each month if your payment comes in after the 1st and the 15th. Your child will be contracted for a certain number of days per month and you will be responsible for these days whether you child attends or not.

MEALS Your child will receive a nutritious breakfast, lunch, and afternoon snack. A monthly menu is available at the beginning of each month and one is posted on the parent bulletin board. If your child has an allergy to any certain food you must provide the staff with a list of food allergies. If you know your child will not eat the lunch served on a particular day it is all right to bring their lunch as long as it contains only nutritional items; preferably a sandwich, chips, fruit or vegetables. We will provide milk. **Breakfast is served at 845.**

APPROPRIATE CLOTHING Dress your child in comfortable clothing. We love seeing them dressed up but feel a bit inhibited when doing messy projects or outside play. Children must have a spare set of clothing in their cubby in case of an accident. MAKE SURE ALL CLOTHING IS MARKED WITH YOUR CHILD'S NAME. We will not be responsible for lost articles although we do everything possible to keep your child's belongings safe and in good shape.

APPROPRIATE SHOES Make sure your child has appropriate footwear. We recommend a closed in shoe such as a sneaker or oxford type for safety reasons. Sandals are easily caught on carpets or playground equipment. We have found boots, sandals, or thongs often dangerous for play. All shoes must have a back strap.

NAP TIME PROCEDURES At Heather Ridge Child Care every child, pre-kindergarten age or under, will be required to rest. Each child will be provided a nap mat and a sheet. They may bring a blanket and a small pillow for naptime.

INCIDENTS AND ACCIDENTS Your child is covered by our liability & medical insurance. Our insurance is secondary to a parent's medical coverage. Your insurance will be billed first and our insurance will pick up any amount not covered by your insurance company, including the deductible. If you do not have medical coverage Heather Ridge will pick up the entire amount. If your child is injured at school you will be notified immediately. If you cannot be reached the physician on the Emergency Release form will be called. We recommend that you leave a signed consent form with your physician for him/her to proceed with emergency treatment in your absence. Every effort will be made to contact you. In life threatening emergencies 911 will be called and you will be notified immediately thereafter. Scratches and scrapes are bound to happen when children play and they will be treated with soap, water, and TLC. A staff member will fill out an accident report form and a copy will be presented to you when you arrive.

ILLNESS We want to keep our center as free from illness as much as possible. It is not fair to the children and the staff to be exposed to the illness unnecessarily. We appreciate your cooperation in keeping our school a healthy place by following the illness policy carefully. Children must be kept at home whenever they have the following symptoms:

FEVER, VOMITING OR DIARRHEA:	**24 hours after the symptoms disappear**
CHICKEN POX	**4 to 7 days or until pox are dry**
CONJUNCTIVITIS (pink eye)	**2 days of treatment**

Children who become ill at school will be made comfortable and their parents notified to pick them up as soon as arrangements can be made.

HOLIDAYS Heather Ridge Child Care will be closed the following holidays:

New Year's Eve	Dec 31st (close at 200 p.m.)
New Year's Day	Jan 1st
President's Day	3rd Monday in February
Memorial Day	Last Monday in May
Independence Day	July 4th
Labor Day	1st Monday in September
Thanksgiving Day + Friday after	4th Thursday in November
Christmas Eve & Christmas Day	December 24th, 25th

(If the holiday falls on a weekend we will be closed the Friday before or the Monday after.)
Two optional days may be taken at the Center's discretion. A thirty day notice will be provided.
The Center also has the right to close for emergency purposes with little to no notice provided.

Heather Ridge Child Care is operated on a nondiscriminatory basis, according equal treatment and access to services without regard to race, color, religion, national origin or ancestry. An otherwise eligible child may not be excluded on the basis of these characteristics. We do, however, reserve the right to terminate enrollment with two weeks written notice if the program does not meet the needs of the child, if a child is chronically ill, or if the parent does not meet the contract requirements.

I agree Heather Ridge Child Care has the right to photograph and retain photos of my child/children for class projects, display and social media.

I understand that I have agreed to pay a registration fee of $50.00 - $90.00, pay the first two weeks in advance, pay on a monthly or bi-weekly basis, and give a two-week notice prior to leaving the center. I also understand my child will be required to rest or nap according to a set schedule.

I have read, understand and agree to the contract statements in the admission policies. I understand that all information is to be kept confidential in nature. I understand and agree to all financial arrangements.

_____ __/__/__ _____ __/__/__

Parent's Signature Date Director's Signature Date

Heather Ridge Child Care

Admission Policy Agreement
CALWORKS/Early Childhood Services

Please read carefully and initial each statement.

___I understand that I have contracted for:

____ Half days (4 hours or less)
____ Full days (over 4 hours)

___The portion of my child's tuition to be paid by CALWORKS or Early Childhood Services is $_____. I understand that I have a monthly co-pay of $_____ due by the 15th of the following month or I may be subject to a late fee.

I agree to pay an extra hour fee of $_____ per hour (or portion thereof) if I am contracted for a half day and leave my child for more than 4 hours.

___I understand that I am responsible for signing my child's voucher on a daily basis. I understand that if I fail to complete my voucher by the last day of each month that I will be charged the **entire per-day tuition amount** for each day left unsigned.

___I understand that I am contracted for a limited time and if I fail to renew my contract with CALWORKS or Early Childhood Services in a timely manner my child's care will be suspended and my child/children may go on a waiting list for re-enrollment.

I have read, understand and agree to the above statements and financial arrangements. All information is to be kept confidential in nature.

Child(ren)'s Name _____ _____

_____ _____

Parent Signature _____ Date _____

Director Signature _____ Date_____

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

IDENTIFICATION AND EMERGENCY INFORMATION
CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME LAST	MIDDLE	FIRST	SEX	TELEPHONE ( )
ADDRESS NUMBER STREET	CITY	STATE	ZIP	BIRTHDATE
FATHER'S NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER STREET	CITY	STATE	ZIP	HOME TELEPHONE ( )
MOTHER'S NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER STREET	CITY	STATE	ZIP	HOME TELEPHONE ( )
PERSON RESPONSIBLE FOR CHILD LAST NAME	MIDDLE	FIRST	HOME TELEPHONE ( )	BUSINESS TELEPHONE ( )

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT OR AUTHORIZED REPRESENTATIVE | DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION | DATE LEFT

Heather Ridge Child Care
820 St. Marks Street
Redding, CA 96003
530-241-7226

Admission Policy Agreement

I understand that I have agreed to:

1. Pay a registration fee of $50.00 / $90.00 (circle one)
2. Pay the first two weeks in advance.
3. Give a two week notice prior to leaving the center.

I understand that I have contracted for _____day per week at half / full time and my child's/children's

tuition is $_____per month and I will be responsible for paying $_____on the 1st of the

month and $_____on the 15th of the month.

I understand that if I fail to pay on the contracted dates my account will be assessed a $25.00 late fee on the 19th of the month. I also understand that I will be charged on days my child is ill and holidays the center is closed.

I have read, understand and agree to the contract statements in the admission policies. I understand that all information is to be kept confidential in nature. I understand and agree to all financial arrangements.

_____ ___/___/___ _____ ___/___/___

PERSONAL RIGHTS

Child Care Facilities

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

(a) Child Care Facilities. Each child receiving services from a child care facility shall have rights which include, but are not limited to, the following:

(1) To be accorded dignity in his/her personal relationships with staff and other persons.

(2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.

(3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.

(4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.

(5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In child care facilities, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s) or guardian(s) of the child.

(6) Not to be locked in any room, building, or facility premises by day or night.

(7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME: Department of Social Services
Community Care Licensing

ADDRESS: 520 Cohasset Road Suite

CITY: Chico, CA | ZIP CODE: 95926 | AREA CODE/TELEPHONE NUMBER: 916 895-5033

DETACH HERE

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE: **PLACE IN CHILD'S FILE**

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY) | (PRINT THE ADDRESS OF THE FACILITY)

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN) | (DATE)

CHILD CARE CENTER
NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.
2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.
3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.
4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.
5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.
6. Receive from the licensee the name, address and telephone number of the local licensing office.

   Licensing Office Name: Community Care Licensing

   Licensing Office Address: 520 Cohosset Rd, Suite 6
   Chico, CA 95926

   Licensing Office Telephone #: 895-6257
7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.
8. Receive, from the licensee, the Caregiver Background Check Process form.

NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.

LIC 995 (ENG/SP) (8/02)

(Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS

(Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of _____, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

Heather Ridge Child Care
Name of Child Care Center

_____ _____
Signature (Parent/Authorized Representative) Date

NOTE: This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/authorized representative.

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S NAME		DOES FATHER LIVE IN HOME WITH CHILD?
MOTHER'S NAME		DOES MOTHER LIVE IN HOME WITH CHILD?
IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?		DATE OF LAST PHYSICAL/MEDICAL EXAMINATION

DEVELOPMENTAL HISTORY (*For infants and preschool-age children only)

WALKED AT* MONTHS	BEGAN TALKING AT* MONTHS	TOILET TRAINING STARTED AT* MONTHS

PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
☐ Chicken Pox		☐ Diabetes		☐ Poliomyelitis	
☐ Asthma		☐ Epilepsy		☐ Ten-Day Measles (Rubeola)	
☐ Rheumatic Fever		☐ Whooping cough		☐ Three-Day Measles (Rubella)	
☐ Hay Fever		☐ Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? ☐ YES ☐ NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF

DAILY ROUTINES (*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*

DIET PATTERN: (What does child usually eat for these meals?)

BREAKFAST

LUNCH

DINNER

WHAT ARE USUAL EATING HOURS?
BREAKFAST _____
LUNCH _____
DINNER

ANY FOOD DISLIKES?

ANY EATING PROBLEMS?

IS CHILD TOILET TRAINED?* ☐ YES ☐ NO	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO	WHAT IS USUAL TIME?*
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? ☐ YES ☐ NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? ☐ YES ☐ NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): ☐ YES ☐ NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? ☐ YES ☐ NO	IF YES, WHAT KIND:

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S SIGNATURE	DATE

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF SOCIAL SERVICES—COMMUNITY CARE LICENSING

PHYSICIAN'S REPORT—CHILD CARE CENTERS
(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____ (NAME OF CHILD), born _____ (BIRTH DATE) is being studied for readiness to enter _____ (NAME OF CHILD CARE CENTER/SCHOOL). This Child Care Center/School provides a program which extends from ____ : ____ a.m./p.m. to _____ a.m./p.m., _____ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

_____ (SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE) _____ (TODAY'S DATE)

PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing:

Vision:

Developmental:

Language/Speech:

Other (Include behavioral concerns):

Comments/Explanations:

Allergies: medicine:

insect stings:

food:

asthma:

other:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	
HEPATITIS B	/ /	/ /	/ /		
VARICELLA (NOT REQUIRED) (CHICKENPOX)	/ /	/ /			

SCREENING OF TB RISK FACTORS (listing on reverse side)

☐ Risk factors not present; TB skin test not required.

☐ Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).

___ Communicable TB disease not present.

I have ☐ have not ☐ reviewed the above information with the parent/guardian.

Physician: _____ Date of Physicial Exam: _____

Address: _____ Date This Form Completed: _____

Telephone: _____ Signature _____

☐ Physician ☐ Physician's Assistant ☐ Nurse Practione

CONSENT FOR EMERGENCY MEDICAL TREATMENT-
Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

_ HEATHER RIDGE CHILD CARE _ TO PROVIDE ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____ . THIS CARE MAY BE GIVEN UNDER WHATEVER
NAME

CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

_____ _____
DATE PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE	WORK PHONE
( )	( )

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

ACKNOWLEDGEMENT OF RECEIPT OF LICENSING REPORTS

I, as the parent/legal guardian of _____, currently attending or newly enrolled at Heather Ridge child care center/family child care home acknowledge I have received the following information as required by Health and Safety Code sections 1596.8595 and 1596.8895.

☒ Copy of any licensing report that documents a Type A deficiency cited at this facility; Type A deficiencies are those that, if not corrected, represent an immediate risk to the health, safety or personal rights of children in care. This includes facility visits and substantiated complaint investigations.

Date(s) of licensing report(s) provided: 10/24/17

☐ Copy of licensing documents pertaining to a conference conducted by a local licensing agency management representative and the licensee of this child care center/family child care home in which issues of noncompliance are discussed.

Date of document provided: _____

☐ Copy of the Accusation Summary indicating the Department's intent to revoke the license of this child care center/family child care home, until that accusation is either dismissed or resolved through the administrative hearing process or stipulated agreement.

Date of document provided: _____

☒ As a parent/legal guardian of a newly enrolled child in this child care center/family child care home, I have been provided the documents identified above received by the licensee during the 12-month period prior to my child's enrollment.

My signature below verifies I have received the documents identified above.

PARENT/LEGAL GUARDIAN SIGNATURE:	DATE DOCUMENTS RECEIVED:

MEAL BENEFIT FORM FOR CHILDREN
YEAR _____

Name of Child Care Center: _____

Please read the instructions. If you need help completing this form call: _____

Complete, sign, and return the form to: _____

1. CHILD INFORMATION
(List names of all children enrolled for care)

Check if a foster child (the legal responsibility of a welfare agency or court).

If all children listed below are foster children, go to #4 to sign this form.

Last	First	M.I.	
1.			☐
2.			☐
3.			☐
4.			☐

2. BENEFITS:
If you are getting CalFresh, CalWORKs, FDPIR, or Kin-Gap benefits for your child, list the case number, and DO NOT complete #3. Go to #4.

CalFresh Case Number:
CalWORKs Case Number:
FDPIR Case Number:
Kin-GAP:

3. ALL OTHER HOUSEHOLD MEMBERS:
Complete this section if you DID NOT complete #2. List all household members. List all income. Go To #4.

NAMES	CURRENT INCOME			
NAMES OF HOUSEHOLD MEMBERS (INCLUDE THE CHILDREN LISTED ABOVE)	EARNINGS FROM WORK BEFORE DEDUCTIONS	CALWORKS, CHILD SUPPORT, ALIMONY	PAYMENTS FROM PENSIONS, RETIREMENT, SOCIAL SECURITY	EARNINGS FROM ANY OTHER INCOME
Example: Jane Smith	*$200 / weekly*	*$150 / every 2 weeks*	*$100 / twice a month*	*$50 / monthly*
1.	$	$	$	$
2.	$	$	$	$
3.	$	$	$	$
4.	$	$	$	$
5.	$	$	$	$
6.	$	$	$	$
7.	$	$	$	$

4. LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (SSN) AND SIGNATURE

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that the CalFresh, CalWORKS, FDPIR, or other eligible program case number is current, correct, or that all income is reported. I understand that this information is being given for the receipt of federal funds; that agency officials may verify the information on the Meal Benefit Form (MBF) and that the deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.)

Printed Name:	
Last Four Digits of SSN:	☐ Check here if no SSN
Signature of Adult:	Date:

PRIVACY ACT STATEMENT

The Richard B. Russel National School Lunch Act (NSLA) requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the SSN of the adult household member who signs the application. The last four digits of the SSN are not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP, or CalFresh), Temporary Assistance for Needy Families (TANF, or CalWORKS) Program, or 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 SSN. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for the administration and enforcement of the program.

The last four digits of the SSN may be used to identify the household member in verifying the correctness of the information stated on the form. This may include program reviews, audits and investigations, and may include contacting employers to determine income, contacting a CalFresh, CalWORKs, or FDPIR office to determine current certification for CalFresh, CalWORKs, or FDPIR benefits, contacting the state employment security office to determine the amount of benefits received, and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported. The last four digits of the SSN may also be disclosed to programs as authorized under the NSLA and the Child Nutrition Act, the Comptroller General of the United States, and law enforcement officials for the purpose of investigating violations of certain federal, state, and local education, and health and nutrition programs.

5. RACIAL/ETHNIC IDENTITY

You are not required to answer these questions.

If you choose to do so, please mark one or more of the following **racial** identities:		
☐ American Indian or Alaskan Native	☐ Asian	☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander		☐ White
Please mark one of the following **ethnic** identities:		
☐ Hispanic or Latino	☐ Not Hispanic or Latino	

U.S. DEPARTMENT OF AGRICULTURE NONDISCRIMINATION STATEMENT

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(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

(3) E-mail: program.intake@usda.gov

This institution is an equal opportunity provider.

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CATEGORICAL ELIGIBILITY CalFresh/CalWORKS/FDPIR household categorically eligible free? ☐ Yes ☐ No Foster child automatically eligible free? ☐ Yes ☐ No	
INCOME ELIGIBILITY Annual Conversion: Weekly times (x) 52, Every 2 Weeks x 26, Twice a Month x 24, Monthl 12	
Total Income:	Household Size:
Eligibility Classification ☐ Free ☐ Reduced-price ☐ Base	
Determining Official (Print Name):	
Determining Official Signature :	Certification Date: