Child's Name _____DOB _____
Classroom _____

Office Use Only

INFORMATION FOR INFANT / TODDLER / PRE-SCHOOL
ENROLLMENT PACKETS

1. Enrollment Packet List
2. GCC/SACC Children's Records Instruction & 2-1 Children's Record Checklist
3. Child's Face Sheet/ Enrollment Form
4. Developmental History
5. First Aid & Emergency Medical Care Consent Form
6. Emergency Card Information
7. Authorization to Release Form
8. Transportation Plan and Authorization
9. Resource Teacher, Student Teachers, Intern Release Form
10. Release Form for Agencies & Programs
11. Permission Slip to Take Child on Walks or Excursion by Bus
12. Permission Form for Topical Non-Prescription Medications
13. Ages and Stages Release
14. Bureau of Nutrition Release Form-Infants Only
15. Application for Free and Reduced Meals/Child & Adult Care Food Program Enrollment Forms (28-1,28-8)
16. Letter to Parents for Fees Due and Payable
17. Creative Curriculum
18. Parent Information
19. Peanut Free Environment Letter
20. Listing of Service Available in the Community with Phone Numbers

GCC/SACC CHILDREN'S RECORDS INSTRUCTIONS

These instructions are to assist you in completing the required children's records checklist. A copy of the current checklist must be submitted to the licensor on the day of the licensing.

1. Child's Name: List all children by name, and below each name indicated the child's date of birth.
2. Developmental History: Indicate with a √ if on file.
3. Progress Reports: Indicate the date of the last progress report on file.
4. Physical Examination: Indicate the date of last physical examination noted on form
5. Lead Screening: If a child is younger than 9 months old, indicate NA (non applicable). If a child is 9 months or older, indicate with a √ that documentation of lead screening is on file.
6. Immunization Record: Indicate with a √ if immunizations are on file and up to date
7. Cover Sheet: Indicate the child's date of admission into the center (this is significant for progress report date and physical).
8. First Aid/ Emergency Hospital/ Child Release: Indicate the date the consent form was signed by the parent or guardian.
9. Field Trip/Off-Site: If a "blanket" permission form is on file for regular neighborhood walks/regular off-site facilities, indicate the date the consent form was signed by the parent or guardian.
10. Injury/Incident Reports: If pertaining to the child, indicate with a √ that the information is on file.
11. Medication Records: If pertaining to the child, indicate with a √ that the information is on file.
12. Referrals: If pertaining to the child, indicate with a √ that the information is on file.
13. Transportation Plan: Indicate the date the plan was signed by the parent or the guardian.
14. Permission to Leave: Indicate the date the consent was signed by the parent or the guardian.

Child Care of the Berkshires, Inc.
Monument Square Early Childhood Center
Child's Face Sheet

Child's Information:

Child's Name _____ Date of Birth _____
Home Address _____ Place of Birth _____
Phone # _____ Primary Language _____ Age at Admission _____
Date of Admission _____

Child's Identifying Information (required by DEEC):

Eye Color _____ Hair Color _____ Sex _____ Height_____
Weight _____ Skin Color _____ Identifying Marks _____
Other in Family (siblings) _____

Parent/Guardian Information:

Name _____ Relationship to Child _____
Place of Birth _____ Birth Date _____
Home Address _____ Phone # _____
Business Name _____ Occupation _____
Hours at Work _____ Bus. Phone _____
E-Mail Address _____

Parent/Guardian Information:

Name _____ Relationship to Child _____
Place of Birth _____ Birth Date _____
Home Address _____ Phone # _____
Business Name _____ Occupation _____
Hours at Work _____ Bus. Phone _____
E-Mail Address _____

Additional Information:

Child's Physician _____ Phone # _____
Allergies/Special Diet _____
Chronic Health Conditions _____
Special Limitations or Concerns _____
Current Medications _____

_____ _____

Parent/Guardian Signature **Date**

Child Care of the Berkshires, Inc.
Monument Square Early Childhood Center
Developmental History

Child's Name _____ **Date of Birth** _____
*Note: Please provide information for Infants and Toddlers marked (*) as appropriate to the age of your child.

Developmental History
At what age did your child begin:
Sitting _____ Crawling _____ Walking _____ Talking _____
*Does your child:
Pull up _____ *Crawl _____ *Walk with support _____
Any speech difficulties? Special words to describe needs
Language spoken at home
*Any history of colic?
*Does your child use pacifier or suck thumb? If so, when?
*Does your child have a fussy time? If so, when? *How do you handle this time?

Health
Any known complications at birth? Serious illnesses and/or hospitalizations:
Special physical conditions, disabilities:
Allergies i.e. asthma, hay fever, insect bites, medicine, food reactions:
Regular medications:

Eating Habits
Special characteristics or difficulties:
*If infant is on a special formula, describe its preparation in detail
Favorite foods: Foods refused:
* Is your child fed held in lap? High chair? * Does your child eat with spoon? Fork? Hands?

Toilet Habits
*Are disposable or cloth diapers used?
*Is there a frequent occurrence of diaper rash?
*Do you use: oil, powder, lotion, other?
*Are bowel movements regular? How many per day?
*Is there a problem with diarrhea or constipation?
*Has toilet training been attempted?
*Describe any particular procedure to be used for your child at the center.

What is used at home:
Potty chair _____ Child seat: _____ Regular seat: _____
How does your child indicate bathroom needs (include special words):
Is your child ever reluctant to use the bathroom? Does the child have accidents?

Sleeping Habits
*Does your child sleep in a crib/bed?

Does your child become tired or nap during the day? If so, when/how long?

Please note: The American Academy of Pediatrics has determined that placing a baby on his/her back to sleep reduces the risk of Sudden Infant Death Syndrome (SIDS). SIDS is the sudden and unexplained death of a baby under one year of age. If your child does not usually sleep on his/her back, please contact your pediatrician immediately to discuss the best sleeping position for your baby. Please also take the time to discuss your child's sleeping position with your caregiver.

When does your child go to bed at night? When does your child get up in the morning?

Describe any special characteristics or needs (stuffed animal, story, mood on walking etc.)

Social Relationships

How would you describe your child?

Previous experience with other children/day care:

Reaction to strangers: Able to play alone:

Favorite toys and activities:

Fears (the dark, animals, etc): How do you comfort your child?

What is the method of behavior management/discipline at home?

What would you like your child to gain from this childcare experience?

DAILY SCHEDULE: Please describe your child's schedule on a typical day.

*For infants, please include waking, eating, time out of crib/bed, napping, toilet habits, fussy time, night bedtime, etc.

Is there anything else we should know about your child?

_____ _____

Parent/Guardian Signature **Date**

Child Care of the Berkshires, Inc.
Monument Square Early Childhood Center
Bureau of Nutrition Release Form *Infants Only

Monument Square Early Childhood Center offers Enfamil Regular and Enfamil Soy/AR formulas for infants.

Name of Formula: _____

(Please circle one) Regular Soy

_____ _____

Parent/Guardian Signature **Date**

The Commonwealth Of Massachusetts
Department of Early Education and Care
First Aid and Emergency Medical Care Consent Form

Child's Name: _____ Date of Birth: _____

I authorize staff in the child care program who are trained in the basics of first aid/CPR to give my child first aid/CPR when appropriate.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and/or to _____ and to secure necessary medical treatment for my child.

Child's physician name, address, and phone number:

Child's Allergies:

Chronic Health Conditions:

Emergency Contacts (In order to be contacted)

Name_____
Address_____
Relationship to child_____ Home Phone_____ Cell_____
Do you give permission for child to be released to this person? Yes_____ No_____

Name_____
Address_____
Relationship to child_____ Home Phone_____ Cell_____
Do you give permission for child to be released to this person? Yes_____ No_____

Name_____
Address_____
Relationship to child_____ Home Phone_____ Cell_____
Do you give permission for child to be released to this person? Yes_____ No_____

Health Insurance Coverage_____ Policy #_____
Parent/Guardian Name: _____ Phone_____ Cell_____

_____ _____
Parent/Guardian Signature **Date**

Child Care of the Berkshires, Inc.
Monument Square Early Childhood Center
Emergency Card Information

Child's Name: _____ DOB: _____
Child's Home Address: _____
Home Phone Number: _____

Instructions to Reach Parent/ Guardian

1. _____
   Name, Address, Phone #
2. _____
   Name, Address, Phone #

Pediatricians or Source of Health Care

1. _____
   Doctor's Name, Address, Phone #

Emergency Contact Person(s)

1. _____
   Name, Address, Phone #
2. _____
   Name, Address, Phone #
3. _____
   Name, Address, Phone #

Medical Emergency Treatment

I hereby give MONUMENT SQUARE EARLY CHILDHOOD CENTER permission to administer basic first aid and/or CPR to my child and/or take my child to a hospital for medical treatment when I cannot be reached or when delay would be dangerous to my child's health.

Insurance Information

Company Name: _____ Policy #: _____
Participating Hospital: _____
Special Instructions: _____

_____ _____
Parent/Guardian Signature **Date**

Child Care of the Berkshires, Inc.
Monument Square Early Childhood Center
Authorization to Release Form

Child's Name: _____

Parent's Name: _____

I hereby authorize Monument Square Early Childhood Center to release my child to the following persons (other than parents):

Name: _____ Relationship: _____

Address: _____ Phone: _____

Name: _____ Relationship: _____

Address: _____ Phone: _____

Name: _____ Relationship: _____

Address: _____ Phone: _____

Please Note:

- CHILD WILL NOT BE RELEASED TO ANYONE UNLESS PARENT NOTIFIES THE CENTER.
- No one under the age of 16 may be an authorized contact person unless pre-approved by CCB/MSQ EEC.
- A copy of any court orders that restricts to whom the child can be released must be on file with Child Care of the Berkshires, Inc.

_____ _____

Parent/Guardian Signature **Date**

The Commonwealth of Massachusetts
Department of Early Education and Care
Small Group/Large Group
Transportation Plan & Authorization

Child's Name: _____ Date of Birth: _____

My child will arrive at the program by:
A.M.

- q Parent drop off
- q Supervised walk
- q Unsupervised walk
- q Public/private/van
- q Program bus/van
- q Contract van
- q Private trans. arranged by parent
- q Other

My child will depart from the program by:
P.M.

- q Parent pick up
- q Supervised walk
- q Unsupervised walk
- q Public/private/van
- q Program bus/van
- q Contract van
- q Private trans. arranged by parent
- q Other

In an effort to ensure our center is appropriately staffed for the number of children at any given time during the day, please fill out your work/school schedule below. If your child utilizes our transportation, and an instance arises where you will be dropping off or picking up, the center requires advance notice. If this is the case, please keep in mind the time your child is usually dropped off or picked up to be brought home on our bus/van. We understand there are extenuating circumstances, but please try to keep times as close to your child's schedule as possible.

_____ _____

Parent/Guardian Signature **Date**

**Refer to first aid & emergency medical care consent form for release information.*

Child Care of the Berkshires, Inc.
Monument Square Early Childhood Center
Specialist Release Form

MSQ has a Child Development Specialist, a Licensed Social Worker, Students and or/Interns from MSQ, MCLA, BCC, Early Intervention and Williams College.

You (the parents) are being informed that these people will be in the classrooms as part of their learning experience and also as a support for our teachers.

They will have direct contact with the children and the teachers.

They will be supervised by the teachers and are obligated to adhere to the same guidelines concerning confidentiality, as are the teachers.

_____ _____

Parent/Guardian Signature **Date**

Child Care of the Berkshires, Inc.
Monument Square Early Childhood Center
Media Release Form

I, the undersigned, do hereby grant or deny permission to Monument Square to use the image of my child, _____. Such use includes the display, distribution, publication, transmission, or otherwise use of photographs, images, and/or video taken of my child for use in materials that include, but may not be limited to, printed materials such as brochures and newsletters, videos, and digital images such as those on the Monument Square Facebook Page Web site.

❑ Deny permission to use my child's image at all.

❑ Grant permission to use my child's image as described above.

_____ _____

Parent/Guardian Signature **Date**

Child Care of the Berkshires, Inc.
Monument Square Early Childhood Center
Topical Non-Prescription Medications Permission Form

Child's Name: _____ Date of Birth: _____

I do hereby give permission to the staff of Monument Square Early Childhood Center to apply topical non-prescription medications (i.e. Vaseline, A&D, Desitin, sunscreen, etc.) on my child as needed.

Vaseline	❑ Yes	❑ No
A&D	❑ Yes	❑ No
Lotion	❑ Yes	❑ No
Sunscreen	❑ Yes	❑ No
Other:	_____	

* We must follow the directions on the original container, unless otherwise authorized by a written order from the child's physicians.

_____ _____
Parent/Guardian Signature **Date**

Child Care of the Berkshires, Inc.
Monument Square Early Childhood Center
Permission Slip

I hereby give the staff at Monument Square Early Childhood Center permission to take my child on walks or excursion by bus.

_____ _____
Parent/Guardian Signature **Date**

Child Care of the Berkshires, Inc.
Monument Square Early Childhood Center
P.O. Box 172
North Adams, MA 01247
Phone: 413-664-4657
Fax: 413-664-4307

Information Release

To: _____
Name of Program or Person

I hereby authorize you to exchange information with Child Care of the Berkshires, Inc., Monument Square Early Childhood Center/Magic Seasons regarding:

Child's Name: _____

Parent/Guardian: _____

Address: _____

Phone: _____

Signed: _____ Date: _____

**This release may be revoked at any time by the person signing it and this person has a right to a copy.*

Child Care of the Berkshires, Inc.
Monument Square Early Childhood Center
210 State Street
North Adams, MA 01247
Phone (413) 664-4657 Fax (413) 664-4307

Physical & Immunization Records Release Form

Child's Name: _____ Date of Birth: _____

Children's records are required by the Department of Early Education and Care for children enrolled in Monument Square Early Childhood Center. Information shared will include child's last physical and date of visit, record of immunizations, lead test results, chronic medical problems, opinion concerning general health and appearance, and information on the child's physical or mental health as it relates to child care.

I, _____, hereby authorize _____
(Parent/Guardian Name) **(Name of Pediatrician)**
to release/exchange physical and immunizations records with Child Care of the Berkshires, Inc. and Monument Square Early Childhood Center.

Please fax records to: 413-664-4307

_____ _____
(Print Parent/Guardian Name) **(Relationship to Child)**

_____ _____
(Parent/Guardian Signature) **(Date)**

Child Enrollment Form FY 18

Child & Adult Care Food Program

Dear Parent/Guardian:

Your child care center _Monument Square_ participates in the United States Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP) administered by the Massachusetts Department of Elementary and Secondary Education.

Meals served must meet nutrition requirements established by USDA's Child & Adult Care Food Program. In order to participate, the child care center has agreed to follow the USDA guidelines. A medical statement from your doctor is necessary if your child cannot eat foods required by the CACFP.

In an effort to assess that these requirements are being met, the USDA and CACFP requires child care centers to annually collect the enrollment information listed below.

Please complete the form and return it to your child care center. Part 1 and Part 3 need to be completed by all families or guardians. Part 2 is to be completed ONLY if enrolling an infant child (under the age of 12 months).

PART 1: CHILD ENROLLMENT INFORMATION

Child's First Name	Last Name	Child's Date of Birth & Age	Beginning Date of Child Care
Times Child Normally Attends For example 7:30 AM – 5 PM ✓ **Box** ☐ **Schedule Varies**	Hours from: _____ to _____ _____ to _____	Check the days your child normally attends ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday	Check the meals you request that your child receives while in care ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

Child's First Name	Last Name	Child's Date of Birth & Age	Beginning Date of Child Care
Times Child Normally Attends For example 7:30 AM – 5 PM ✓ **Box** ☐ **Schedule Varies**	Hours from: _____ to _____ _____ to _____	Check the days your child normally attends ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday	Check the meals you request that your child receives while in care ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack
Child's First Name	Last Name	Child's Date of Birth & Age	Beginning Date of Child Care
Times Child Normally Attends For example 7:30 AM – 5 PM ✓ **Box** ☐ **Schedule Varies**	Hours from: _____ to _____ _____ to _____	Check the days your child normally attends ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday	Check the meals you request that your child receives while in care ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

If there are other children in care, please complete additional forms as needed.

FOR SPONSOR OFFICE USE ONLY

Effective Date of this Enrollment Form: _____ Fiscal Year _____

The effective date can be made retroactive back to the first day the child participates In the CACFP as long as it occurs in the same month this form is received.

PART 2: INFANT MEAL NOTIFICATION (Birth through 11 months)

Nutritious meals meeting the United States Department of Agriculture guidelines are served to all children enrolled in this program, including children under the age of 12 months. The child care center must meet the meal component requirements based on age and development outlined in the Infant Meal Pattern. The child care center will give you a copy of the minimum meal components and portion requirements to be served according to the child's age.

I understand that this child care center will serve the iron fortified formula _____ to my infant while in care.
(Name of Iron Fortified Infant Formula)

To help provide the best nutritional care for your infant, please complete the following information.

IF YOU *FORMULA-FEED* YOUR INFANT, PLEASE CHECK ONE OPTION

☐ I prefer to have the center supply the formula offered. **OR** ☐ I will supply formula for my infant child.

IF YOU *BREAST-FEED* YOUR INFANT, PLEASE CHECK

☐ I will supply expressed (pumped) breast milk for my infant child.

I understand that this child care center will supply infant cereal and infants foods for infants 6 months and older as they are developmentally ready according to the CACFP requirements.

☐ I prefer to have the center supply infant cereal and infant foods. **OR** ☐ I will supply infant cereal and infant foods for my infant child

PART 3: PARENT OR GUARDIAN ACCEPTANCE AND SIGNATURE

I have read this child enrollment form and request that my child receive the above Child and Adult Care Food Program benefits. I have received a copy of this completed form.

Parent's Signature Date Signed (form must be completed annually)

Parent's Name: _____ Home Phone: _____
: Please Print

Mailing Address: _____ Work Phone: _____

City, State, Zip: _____ Cell Phone: _____

CIVIL RIGHTS: This information is voluntary and will not affect your children's eligibility. Please indicate the ethnic and racial identity of your children by checking a box in each of the categories. This information is being collected to assure that everyone receives CACFP benefits on a fair basis.

1. **Ethnic Identity** □ HISPANIC OR LATINO □ NOT HISPANIC OR LATINO.
2. **Racial Identity** □ AMERICAN INDIAN OR ALASKA NATIVE □ ASIAN □ BLACK OR AFRICAN AMERICAN
   □ NATIVE HAWAIIAN or OTHER PACIFIC ISLANDER □ WHITE.

For questions please contact: Terry Hartman 413-664-3256 @ Child Care of the Berkshires, Inc.

This institution is an equal opportunity provider.

CCB DEMOGRAPHICS DATA SHEET FY2018

The services we provide to some families are partially paid by grant funding. We are asked to collect certain information only to show who benefited from this money. We appreciate you taking the time to complete this confidential information. We will not report this information to any other source with your name.

Your Name: _____ Date: _____
Town of Residency: _____ CCB Program:_____
Partner's Name (if applicable): _____
***For additional children, please fill out an additional page.*

☐ I have no children (please check this box if you are currently pregnant)

CHILD ONE:
What ethnicity do you consider this child? (please check **ONLY** one box):
☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Non-Resident Alien ☐ Unknown ☐ Other
What race do you consider this child? (please check **ALL** that apply):
☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White
☐ American Indian/Alaskan Native ☐ Other ☐ Multiracial ☐ Decline
Child's Date of Birth: _____ What is the gender of this child? ☐ Male ☐ Female ☐Transgender
Child's Age: _____
Child's Country of Birth: _____ Is this child enrolled in a program? ☐ Yes ☐ No CCB Program: _____

CHILD TWO:
What ethnicity do you consider this child? (please check **ONLY** one box):
☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Non-Resident Alien ☐ Unknown ☐ Other
What race do you consider this child? (please check **ALL** that apply):
☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White
☐ American Indian/Alaskan Native ☐ Other ☐ Multiracial ☐ Decline
Child's Date of Birth: _____ What is the gender of this child? ☐ Male ☐ Female ☐Transgender
Child's Age: _____
Child's Country of Birth: _____ Is this child enrolled in a program? ☐ Yes ☐ No CCB Program: _____

CHILD THREE:
What ethnicity do you consider this child? (please check **ONLY** one box):
☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Non-Resident Alien ☐ Unknown ☐ Other
What race do you consider this child? (please check **ALL** that apply):
☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White
☐ American Indian/Alaskan Native ☐ Other ☐ Multiracial ☐ Decline
Child's Date of Birth: _____ What is the gender of this child? ☐ Male ☐ Female ☐Transgender
Child's Age: _____
Child's Country of Birth: _____ Is this child enrolled in a program? ☐ Yes ☐ No CCB Program: _____

YOUR INFORMATION:

What ethnicity do you consider yourself? (please check **ONLY** one box):

☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Non-Resident Alien ☐ Unknown ☐ Other

What race do you consider yourself? (please check **ALL** that apply):

☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White

☐ American Indian/Alaskan Native ☐ Other ☐ Multiracial ☐ Decline

Highest level of education you have completed: (please check **ONLY** one):

☐ Les than 9th grade ☐ 9th-12th grade ☐ High School Grad/GED ☐ Some College (no degree)

☐ Associate's degree ☐ Bachelor's degree ☐ Post Grad ☐ Decline

Date of Birth: _____ Age: _____ What is your gender? ☐ Male ☐ Female ☐Transgender

Country of Birth: _____ **Primary Language spoken at home:**

TOTAL NUMBER OF MEMBERS IN YOUR HOUSEHOLD (include only those living with you): _____

MARITAL STATUS OF HOUSEHOLD:

☐ Married ☐ Cohabitating/Living with Partner ☐ Single/Never Married ☐ Divorced/Separated

☐ Widowed ☐ Other ☐ Decline

HOUSEHOLD INCOME (only include income in the household/please include child support/TAFDC/SSI)**:**

☐ 0-$10,000 ☐ $10,001-14,999 ☐ $15,000-24,999 ☐ $25,000-34,999

☐ $35,000-49,999 ☐ $50,000-74,999 ☐ $75,000 + ☐ Decline

DOES YOUR FAMILY RECEIVE ANY OF THE FOLLOWING FINANCIAL SUPPORT?:

☐ SNAP Benefits (food stamps) ☐ WIC (Women Infants Children) ☐ Public Housing (Section 8)

☐ Health Insurance (Medicare/Medicaid) ☐ Free or Reduced Lunch ☐ Scholarship ☐ TAFDC

☐ Social Security (SSI/SSD) ☐ Fuel Assistance ☐ Child Care Subsidy ☐ Other: _____

PLEASE INDICATE OTHER CCB PROGRAMS THAT YOU HAVE USED:

☐ FRC Clothing Exchange ☐ Parent Child Home Program ☐ Parent Education Series ☐FRC Newsletter

☐ Healthy Families Home Visiting ☐ PAT Group (Parents as Teachers) ☐ Parenting Partnership Home Visiting

☐ Play and Learn Groups ☐ Center Based Child Care ☐ Young Parent Child Care Program

☐ Childhood Lead Poisoning Prevention Program ☐ Family Child Care

Thank you for your participation.

PARTNER INFORMATION (If applicable):

Do you live in the same household? ☐ Yes ☐ No

What ethnicity do you consider yourself? (please check **ONLY** one box):

☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Non-Resident Alien ☐ Unknown ☐ Other

What race do you consider yourself? (please check **ALL** that apply):

☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White

☐ American Indian/Alaskan Native ☐ Other ☐ Multiracial ☐ Decline

Highest level of education you have completed: (please check **ONLY** one):

☐ Les than 9th grade ☐ 9th-12th grade ☐ High School Grad/GED ☐ Some College (no degree)

☐ Associate's degree ☐ Bachelor's degree ☐ Post Grad ☐ Decline

Date of Birth: _____ Age: _____ What is your gender? ☐ Male ☐ Female ☐Transgender

Country of Birth: _____

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care) FY 18

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. **Monument Square** offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached Meal Benefit Income Eligibility Form. In addition, by filling out this form, we will be able to determine if your child(ren) qualifies for free or reduced price meals.

1. Do I need to fill out a Meal Benefit Form for each of my children in day care? You may complete and submit one CACFP Meal Benefit Income Eligibility Form for all children enrolled in child care in your household **only** if the children in child care are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. **Return the completed form to: Monument Square 210 State St. North Adams, MA 01247.**

2. Who can get free meals without providing income information? Children in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps) or Temporary Assistance for Families of Dependent Children (TAFDC), benefits can get free meals. Foster children and children enrolled in Head Start are also eligible for free meals. Children in households participating in WIC may be eligible for free meals.

3. Who can get reduced price meals? Your children can get low cost meals if your household income is within the reduced price limits on the Federal Income Chart, shown on this application. Children in households participating in WIC may be eligible for reduced price meals.

4. May I fill out a form if someone in my household is not a U.S. citizen? Yes. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center.

5. Who should I include as members of my household? You must include everyone in your household (such as grandparents, other relatives, or friends who live with you) who shares income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you.

6. How do I report income information and changes in employment status? The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income Chart, the center will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or by providing a current SNAP, TANF, FDPIR case number, you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the eligibility standards.

7. What if my income is not always the same? List the amount that you normally get. For example, if you normally get $1000 each month, but you missed some work last month and only got $900, put down that you get $1000 per month. If you normally get overtime, include it, but not if you only get it sometimes.

8. What if I have foster children? Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the Meal Benefit Form, but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children should contact **Terry Hartman 413-664-3256**

9. We are in the military, do we include our housing and supplemental allowances as income? If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex, age or disability.

If you have other questions or need help, call **Terry Hartman 413-664-3256.**

INSTRUCTIONS FOR COMPLETING THE CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

If any member of the household gets SNAP or TAFDC, follow these instructions:

Part 1: List all enrolled children and household members. For any person, including children, with no income, you must check the "No Income Box".
Part 2: List the case number for any household member receiving SNAP or TAFDC benefits.
Part 3: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call your Child Care Sponsor for further instructions. If not, skip this part.
Part 4: Skip this part
Part 5: Sign the form. The last four digits of a Social Security Number are **not** necessary.
Part 6: Answer this question if you choose.

If you are applying on behalf of a FOSTER CHILD, follow these instructions:

If **all** children you are applying for are foster children, or if you are only applying for benefits for the foster child:
Part 1: List all foster children**.** Check the box indicating that the child is a foster child.
Part 2-4: Skip this part.
Part 5: Sign the form. A Social Security Number is **not** necessary.
Part 6: Answer this question if you choose to.

If some of the children in the household are foster children.

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster child.
Part 2: If the household does not have a case number, skip this part.
Part 3: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call your Child Care Sponsor for further instructions. If not, skip this part.
Part 4: Follow these instructions to report total household income for this month or last month.

Column A – Name: List only the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the **gross income,** not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your pay stub or your boss can tell you.
Box 2: List the amount each person got for the month from welfare, child support, alimony.
Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.
Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. Report income after expenses in Box 1 only if self-employed. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.
Part 6: Answer this question if you choose.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box."
Part 2: Skip this part.
Part 3: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call your Child Care Sponsor for further instructions. If not, skip this part.
Part 4: Follow these instructions to report total household income form this month or last month.

Column A – Name: List only the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the **gross income,** not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your paystub or your boss can tell you.
Box 2: List the amount each person got from the month from welfare, child support, alimony.
Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.
Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. Report income after expenses in Box 1 only if self employed. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC

or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

Privacy Act Statement: This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.

Part 1. All Household Members

Name of Enrolled Child(ren):

Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Part 2. Benefits: If any member of your household received SNAP or TAFDC cash assistance, provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:____ CASE NUMBER: ___________________________________

Part 3. If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call the Child Care Sponsor at Phone #: Homeless ❑ Migrant ❑ Runaway❑

Part 4. Total Household Gross Income—You must tell us how much and how often

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

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

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

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

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City:_____ State: _____ Zip Code: _____

Last four digits of Social Security Number: _*_*_*-_*_*-____ ❑ I do not have a Social Security Number

Part 6. Participant's ethnic and racial identities (optional)

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

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

Categorical Eligibility: ___ Eligibility: Free___ Reduced___ Denied___

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

Effective July 1, 2017 to June 30, 2018	
Household size	**Yearly**
1	22,311
2	30,044
3	37,777
4	45,510
5	53,243
6	60,976
7	68,709
8	76,442
Each additional person:	+ 7,733

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

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, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

SHARING INFORMATION WITH MEDICAID/SCHIP

Dear Parent/Guardian:
If your children qualify for free or reduced price meals, they may also be able to get free or low cost health insurance through Medicaid or the State Children's Health Insurance Program (SCHIP). Children with health insurance are more likely to get regular health care and are less likely to become sick.

Because health insurance is so important to children's well-being, **the law allows us to tell Medicaid and SCHIP that your children are eligible for free or reduced price meals, *unless you tell us not to***. Medicaid and SCHIP only use the information to identify children who may be eligible for their programs. Program officials may contact you to offer to enroll your children in this health insurance program. Filling out the CACFP Meal Benefit Income Eligibility Forms does not automatically enroll your children in health insurance.

If you do not want us to share your information with Medicaid or SCHIP, fill out the form below and send it with your Income Eligibility Form to your Child Care Center. (Sending in this form will not change whether your children get free or reduced price meals.).

❑ **No! I DO NOT** want information from my CACFP Meal Benefit Income Eligibility Form shared with Medicaid or the State Children's Health Insurance Program.

If you checked no, fill out the form below.

Child's Name: _____

Child's Name: _____

Child's Name: _____

Child's Name: _____

Signature of Parent/Guardian: _____ Date: _____

Print Your Name: _____

Address: _____

For more information, you may call **Terry Hartman 413-664-3256**

If your child is eligible for free or reduced school meals, your child may also be eligible for **free or low cost health insurance** through MassHealth.

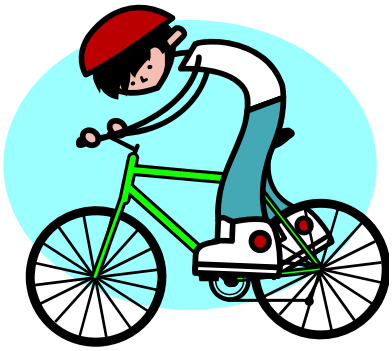
To learn more call: 1-800-841-2900

MassHealth

Si su niño es eligible para almuerzo gratís o reducido, su niño pueda ser eligible para **seguro de salud gratís o de bajo costo** por medio de MassHealth.

Para saber mas, llame al: 1-800-841-2900

Covering Kids



Child Care of the Berkshires, Inc.
Monument Square Early Childhood Center
Billing Information

Dear Parents,

Welcome to Child Care of the Berkshires! We hope that your child's enrollment in our day care program will be a fulfilling experience. You have signed a fee agreement with the director of the program. That fee agreement states that fees are due one week in advance and payable on the Friday before care is given. Monday is the billing date for the week; please keep in mind that in some months there will be 5 Mondays. Initial fees are adjusted as the regular fees increase or decrease. Please refer to your fee agreement concerning our policies regarding vacations, holidays, snow days, etc. All billing and accounts maintenance is performed in the Administrative Office in North Adams. Payments may be made in person at the North Adams Office, the child care center in which your child is enrolled or may be mailed to:

Child Care of the Berkshires, Inc.
P.O. Box 172
North Adams, MA 01247

The purpose of your statement is to give you a "snapshot" of your account at one point in time. It is not a bill. You can see charges, adjustment to the account, and payments (with check numbers) for your review. If a statement is not received, nevertheless your weekly payment is still expected. Please feel free to ask any questions you may have. Any payments not made by the last Monday of the month may be subject to a late fee assessed on the account as stated in the fee agreement.

Please direct payment inquiries to:

Lory Atwell
413-663-6593 Ext 49

PARENT INFORMATION

The General Laws of the Commonwealth of Massachusetts mandates to the Department of Early Education and Care the legal responsibility of promulgating and enforcing rules and regulations governing the operation of child care centers (including nursery schools), and school age child care programs.

These regulations, 102 CMR 7.00, establish minimum standards for operation of group child care and school age child care programs in the Commonwealth. The regulations require certain things of licensees (child care program owner) in regard to their work with parents. A summary of the required parent information, rights, and responsibilities follows.

Parental Input. The licensee must appropriately involve parents of children in care in visiting the program, meeting with the staff and receiving reports of their children's progress. The program must have a procedure for allowing you to give input and make suggestions, but it is up to the program to decide whether or not they will be implemented.

- **Meeting with parents.**

In group child care programs, the licensee shall assure that the administrator or his designee meets with the parent(s) prior to admitting a child to the program. The parents shall have an opportunity to visit the program's classrooms at the time of the meeting or prior to the enrollment of the child. In school age programs, the licensee shall provide an opportunity for the parent(s) and child to visit the program and meet the staff before the child's enrollment.

- **Parent Information.**

The licensee must provide to the parents upon admission of their child the program's written statement of purpose, including the program philosophy, goals and objectives, and the characteristics of children served; information on the administrative organization of the program, including lines of authority and supervision; the program's behavior management policy; the program's plan for referring parents to appropriate social, mental health, education and medical services for children; the termination and suspension policy; a list of period. You must be allowed to view your child's entire record, even if it is maintained in more than one location. The center must have procedures governing access to, duplication of, and dissemination of children's record, and must maintain a permanent, written log in each child's record which identifies anyone who has had access to the record or who has received any information from the record. This log is available only to you and the people responsible for maintaining the center's records.

- **Amending your child's record.**

You have the right to add information, comments, data, or any other relevant materials to the child's record. You also have the right request deletion or amendment of any information contained in your child's record. If you believe that adding information is not sufficient to explain, clarify or correct objectionable material in your child's record, you have the right to a conference with the licensee to make your objections known. If you have a conference with the licensee, the licensee must inform you in writing within one week of his decision regarding your objections. If the licensee decides in your favor, he must immediately take the steps necessary to put the decision into effect.

- **Transfer of Records.**

When your child is no longer in care, the licensee can give your child's record to you, or any other person you identify, upon your written request. Charge for Copies. The licensee shall not charge an unreasonable fee for copies of any information contained in your child's record.

PROGRAM RESPONSIBILITIES

Providing Information to the Department The program must make available any information requested by the Department to determine compliance with any Department regulations governing the program, by providing access to its facilities, records, staff and references.

- **Reporting abuse or neglect**

All center staff are mandated reporters. They are required by law to report suspected abuse and neglect to either the Department of Social Services or to the licensee's program administrator. The licensee must have written policies and procedures for reporting and must provide the written policy to you upon enrollment.

- **Notification of injury**

The licensee must notify you immediately of any injury which requires emergency care. The licensee must also notify you, in writing, within 24 hours, if any first aid is administered to your child.

- **Availability of EEC Regulations**

The program must maintain a copy of the regulations, 102 CMR 7.00: Standards for the Licensure or Approval of Group Day Care and School Age Child Care Programs, on the premises of the center and must make them available to any person upon request. If you have a question about any of the regulations, ask the center to show them to you.

Child Care of the Berkshires, Inc.
Monument Square Early Childhood Center
Peanut Free Environment

Dear Parent(s)/Guardian(s):

Just a reminder that we are a peanut free environment. We do not serve peanuts or peanut products due to the fact that we have some children with severe peanut allergies. Therefore we would request that you not send in any peanuts or peanut products. We also ask that you refrain from sending in home-made items.

Thank you.

Sincerely,

Kelly Phillips, Program Director
Monument Square Early Childhood Center

Child Care of the Berkshires, Inc.
Monument Square Early Childhood Center
Facebook Group Invitation

Dear families,

Please join our MSQ Enrolled Children Parent Group on **Facebook**. We invite everyone to request an "add" to the group! This group is designed for parents/guardians of current MSQ families to interact with teachers and staff, get updates on events, reminders from teachers and staff and a glimpse of activities and projects happening in our classrooms! This is a closed group. All members must request to be added and then approved by an admin in order to ensure all parents in the group are currently enrolled in our program. If for any reason your child leaves our program, you will be removed from the group.

We invite you to connect with other parents, ask questions when relevant and stay connected with your child's education. To find our group type ***MSQ Enrolled Children Parent Group*** in the search bar and request to be added. Welcome to our group!

Sincerely,

Laurie Singer and the
Monument Square Staff

Teaching Strategies Gold™ Online

Dear Families:

We are very excited to invite you to participate in our program by communicating with us through *Teaching Strategies GOLD™ online*! Accurate assessment of your child's development and learning is an essential part of our program because it enables us to plan meaningful activities that match his or her strengths, needs, and interests. To accomplish that, our program uses the online version of *Teaching Strategies GOLD™*, an exciting assessment, reporting, and planning system. It helps us collaborate with you as we follow your child's progress and plan our program.

The *Teaching Strategies GOLD™* family site makes it easy to communicate with you about your child's ongoing development and our classroom activities. We hope you will use the family resources available on this online system. There is no fee for you to use them.

Through the family site, you will be able to:

• Use our **messaging system** and **event calendar** to keep in touch with us and stay up-to-date about what your child is doing at school. You will also be able to view our **weekly planning forms** so you will know about both special events and our day-today classroom activities.

• View the documentation we enter to show what your child knows and is able to do. That includes photos, scanned artwork, and other electronic samples of his or her work and play at school. You can also share your documentation with us by entering it in the system!

• View reports about your child's development and learning. The "**Development and Learning Report**" shows your child's current knowledge and skills and what his or her next developmental steps are likely to be. On the basis of your child's current levels of development, the report also recommends fun activities that are related to our curriculum so that you can support your child's learning at home.

• Prepare for family–teacher conferences by viewing the "**Family Conference Form**" we fill out for your child. During the conference, we will use the information on the form to begin our conversation and together plan ways to support your child's continued development.

To send invitations to use *Teaching Strategies GOLD™* family tools and resources, I need the e-mail address of each adult family member to whom you would like us to give access. Please complete the attached registration form for each person you want us to invite. Then please return it to me.

When we receive your e-mail address, we will send an invitation that can be accepted by clicking on the link in the message. You will be asked to register (at no cost) by selecting a username and password. Once you have registered, you will be able to log in.

You can visit the family site through any computer with access to the Internet. Go to www.TeachingStrategies.com or www.TeachingStrategies.com/gold/parents. When the homepage appears, log in by entering your username and password.

Please feel free to ask us about *Teaching Strategies GOLD™*. I look forward to having this additional resource for partnering with you in your child's education. Thank you for supporting our program!

YES! Please invite me to the Teaching Strategies GOLD family site!

Please complete this form. Include all adults in your family who would like to participate.

Child's Name: _____

Teacher's Name: _____

My Name: _____

Email address: _____

Other authorized adult's name: _____

Email address: _____

Other authorized adult's name: _____

Email address: _____

_____ _____

(Parent/Guardian Signature) (Date)