COMMUNITY CHILD CARE CENTER
TUITION INFORMATION / AGREEMENT
COLFAX
Effective date: September 1, 2024

Child's Name: _____ **Siblings:** _____

Person responsible for paying tuition / copayment: _____

Address: _____

Source of payment: **Personal funds_____** **DSHS Subsidy_____** **Financial Aid/Loans_____**

Tuition is to be paid in advance and is due by the 10th of the month. Any account not paid in full by the 1st of the following month may be assessed a late fee of 1.5% on the balance. You will be charged a monthly rate (see below) based on the schedule that you need. Any changes to the schedule must be given to us with as much advance notice as possible. New tuition rates take affect September 1st. Parents will be notified in writing of any changes in fees at least four weeks in advance. **You can receive a 3% discount if you sign up to make your payments electronically with your bank account. We also accept checks, credit and debit card payments.**

Tuition Policy: There will be no tuition credit given for occasional days missed, holidays that CCCC is closed or personal vacation days. During extended leaves, CCCC will provide a 50% tuition discount to children who are absent for 3 or more consecutive weeks. If a child is absent for one month or more, no tuition will be charged.

Community Child Care Center accepts DSHS subsidized childcare. Arrangements must be made by the parent/guardian through DSHS. Children accepted on subsidized childcare must have written verification on file with CCCC prior to enrollment. Parents/guardians are responsible for any hours of service beyond DSHS authorizations and all co-payments as well as any late fees or fines.

Parents need to call when their child will be absent from the center.

Our operating hours are **7:30 a.m. to 5:30 p.m**. We need parents to respect these hours.

Late Charges: We will charge $15.00 per child for any pickup time between 5:30pm-5:45pm. Each minute after 5:45pm will be charged $1.00 a minute per child.

School Year 2024/2025 tuition:

Days per week:	**5**	**4**	**3**	**2**	**1**
Tuition per month:					
Full time	$1,049	$835	$628	$420	$213
Part time (5 hrs / day)	$579	$468	$350	$234	$128
After School	$390	$322	$245	$170	$95
Before School (7:30 - 8:05)	$64	$53	$41	$30	$20
If less than 5 days per week, please indicate which days your child will attend:					
	M	T	W	TH	FR

Drop-in rates will be $10.00 per hour.

Please call to check on availability before dropping off your child!

Please circle above and/or indicate here what schedule you will need for this school year: _____

I have read the above agreement and accept the conditions stated herein. I have received the parent handbook, which includes important policies and procedures including the Internal Disaster Plan and Pesticide Policy.

Signature _____ **Date**_____
Parent/Legal Guardian

COMMUNITY CHILD CARE CENTER

Head Start/EHS/ECEAP/Child Care

FOR OFFICE USE ONLY
DEPOSIT PAID $_____DATE_____
DISENROLLMENT DATE_____
❑ FOOD ALLERGY
❑ HEALTH CONDITION
❑ SOCIAL / FAMILY CONCERN

EMERGENCY AND MEDICAL INFORMATON FORM

Child's Name _____ Birthday _____ Gender_____ Start Date_____

School Age Children Only_____
School Grade

Primary residence of child is with: _____ _____

Are there any court orders/parenting plans in effect concerning the custody of the child? **□Yes** **□No**
If so, please provide us with a copy of these documents prior to enrollment.
Is your family currently involved with the State of Washington Department of Children, Youth & Families (CPS)?
□ Yes **□ No**

_____(___)_____(___)_____
Legal Guardian Name Home Phone Cell Phone Email Address

_____(____)_____
Address of Guardian Place of Employment Work Phone

_____
The best way to reach me (i.e. email, text, phone call) The best time to reach me

_____(___)_____(___)_____
Legal Guardian Name Home Phone Cell Phone Email Address

_____(____)_____
Address of Guardian Place of Employment Work Phone

_____
The best way to reach me (i.e. email, text phone call) The best time to reach me

---

Local Emergency Contacts (These persons are authorized to pick up the child):

1._____ (____)_____
Name Relationship to Guardian Phone Number(s)

2._____ (____)_____
Name Relationship to Guardian Phone Number(s)

Physician/Dentist Information:

_____(___)_____(___)_____
Physician Name Phone Last Appt. Date Dentist Name Phone Last Appt. Date

*(if you do not have a Doctor or Dentist please let our staff know and we can provide you with a list of local providers)

Medical Insurance Information:

Company: _____Plan Number: _____

Allergy & Medical History

Allergies, medication/medical conditions_____ If none, check here _____

Permission for Emergency Treatment

At the time of an emergency, medical treatment is urgent. I authorize Community Child Care Center staff to call emergency aid (911) or transport my child to the nearest hospital or my child's physician to receive immediate care. I also give permission for CCCC to give first aid for minor injuries. I understand that I will be responsible for all expenses connected with the seeking of emergency care.

Signature _____ **Date**_____

Revised 2020

Community Child Care Center

530 NW Greyhound Way, Pullman, WA 99163 (509) 334-9290 Head Start/EHS/ECEAP/ Child Care

PARENT CONSENT FORM

_____
Child's Name

I give permission for the following services to be provided to my child. I understand that by circling "yes," permission is granted for the specific service and by circling "no," permission is not granted, and my child will be excluded from the activity.

Example of specific tools:

0–3-year-old children receive: **Ages and Stages Developmental Checklist** **HELP- Hawaii Early Learning Profile** **Hearing, vision, height, & weight screenings**	**3–5-year-old children receive:** **ESI-R** – *Motor, Cognitive, and Language Screen designed to identify children who may be in need of further developmental evaluation* ***Teaching Strategies Gold Dev. Assessment*** **Hearing, vision, height, & weight screenings**

Yes / No - I grant permission for my child to receive all standard screenings and assessments used by the program, age appropriate for my child. These tools are used to assess children in the areas of language and cognition, visual and auditory, fine and gross motor, physical growth, and social/emotional development. The results will be used to plan appropriate curriculum for your child and determine the need for any further evaluations. All results are shared with parents.

Yes / No - I grant permission for an employee to **apply sunscreen (Banana Boat SPF 30 or higher), lip balm, lotion and/or diaper ointment (A+D Diaper Ointment)** if applicable to my child when necessary.

Yes / No – I grant permission for my child to use hand sanitizers or hand wipes with alcohol (if over 24 months) when necessary.

Yes / No - I grant permission for my child to use toothpaste with fluoride daily (if over 24 months).

Yes / No - I grant permission for my child to be **photographed or videotaped** by staff and/or childcare parents.

Yes / No - I grant permission for my child's **photographs to be hung up in the classrooms.**

Yes / No - I grant permission for **pictures or videotapes** of my child be taken and used in **advertising, newspapers, newsletters, displays**, **CCCC's FACEBOOK page**, or other types of educational/promotional publications.

Yes / No - I grant permission for my child to leave the school premises under the supervision of staff members for visits to close-by parks and **field trips** in an authorized vehicle with a notice ahead of time.

Yes / No - I grant permission for CCCC/HS/EHS/ECEAP to provide transportation for my child. I hereby give permission to the staff to sign my child in and out of the program when my child is being **transported by CCCC and during emergency situations (e.g. COVID-19 pandemic).** Washington state law requires parents to sign their children in upon **arrival and upon departure** out of the center.

Yes / No - I grant permission for CCCC to share/consult with CCCC's Contracted Registered Nurse regarding my child's health.

Yes / No - I grant permission for administrators, teaching staff, and regulatory authorities, on request, to **access my child's file**. I understand that as a parent or legal guardian, I also will be granted immediate access to my child's records upon request.

_____ _____ _____
Parent Signature Staff Signature Date

Introducing My Family and Me

Child's formal name: _____Age: _____

Name my child likes to be called: _____

Race/Ethnicity/Family Structure and traditions that are important to our family:

_____

_____

My child lives with these adults:

_____

_____

My child lives with _____ other children. Their names and ages are:

_____

_____

My child is close to:

____Mom/Mama ____Aunt/Tia _____ Others/Ostros (please explain): _____
____Dad/Papa ____Uncle/Tio _____
____Grandfather/Abuelo ____Step Mom/Madrastra _____
____Grandmother/Abuelita ____Step Dad/Padrastro _____

We speak the following languages in our family: _____

_____

Has your child been in any of the following settings?

____Preschool ____In home childcare setting ____Never been in care
____Child Care ____Watched by family/friend

Please describe your child's personality:

_____

_____

What activities does your child really enjoy?

_____

_____

Does your child have any fears or phobias we should know about or has your child experienced any traumatic events?

_____

_____

How do you think your child will respond to new things they might experience in the classroom setting?

_____

_____

What helps your child respond to new social settings or new challenges?

_____

_____

What do you think might be challenging for your child?

_____

_____

As their guardian what is the most important thing you would want me, their teacher, to know about your child?

_____

_____

What skills do you want your child to develop and work on while in the classroom?

_____

_____

Additional Comments:

_____

_____

_____

COMMUNITY CHILD CARE CENTER
530 NW Greyhound Way Pullman, WA. 99163 (509) 334-9290 Head Start/EHS/ECEAP/Child Care

CCCC Health History Form (1-5 years)

Child's Name (Last, First, Middle)	Sex	Birth Date (MM/DD/YY)	Country of Birth

Health History

Name of child's Health Care Provider			
Name of child's Dentist			
		Child's Weight at Birth: Pounds_____ Ounces_____ Grams_____	
		Type of Delivery:	
Yes	No	Please Answer the Following:	
		Were you told your child was born early or premature? How Early?	
		Were drugs, alcohol or cigarettes part of family life during pregnancy?	
Does your child have any of the following?			
Yes	No	Health Concerns	If yes, Describe:
		1. Anemia	
		2. Breathing Problems* (Asthma, RSV, RAD, other) Must answer the question on the right. Do not leave blank.	When was the last time your child had to use medication for the breathing problem? _____ Has your child been hospitalized overnight two or more times in the past year for breathing problems? ☐Yes ☐No Has your child been seen in the emergency room three or more times in the past year for breathing problems? ☐Yes ☐No Comments:
		3. Bowel/bladder problems	
		4. Diabetes*	
		5. Frequent ear aches or infections	
		6. Hearing Concerns	
		7. Heart Conditions*	
		8. Frequent nose bleeds	
		9. Seizures*	

Child Health Plan Required/Potentially life-threatening condition

Yes	No	Health Concern	Is Yes, Describe:
		10. Skin condition	Is medication or lotion applied at home?? ☐Yes ☐No Are there things to avoid (e.g. certain soaps, grass, water play)? ☐Yes ☐No Comments:
		11. Tuberculosis Exposure	
		12. Walking/climbing difficulties	
		13. Vision concerns/wears glasses	
		14. Secondhand smoke exposure	
		15. Lead Exposure a. Lived in a house with peeling paint built before 1978? b. Has a sibling/relative or close friend with lead poisoning? c. Lives with an adult whose job or hobby involves lead? (i.e. welding, stained glass or pottery) d. Lived near a smelter/battery plant/car repair shop or other lead related industry? e. Have you or your family used home remedies such as azareon, greta, kohl, or pavlooah? (Circle all that apply).	
		16. Has your child ever been tested for lead?	
		17. Other health concerns? (Please List)	
		18. Has your child experienced any of the following? Chicken Pox, Measles, Mumps, Whooping Cough, other? Please describe.	
		19. Has your child experienced any serious illness/injury, surgery, or seen a specialist? If yes, when and for what?	
		20. Is tobacco currently in use in your home (i.e. smokeless tobacco, cigars, pipe, cigarettes?	
		21. Are drugs or alcohol currently in use in your home?	
		22. Has your child been exposed to violence in the home?	
Time (Hours)		23. How much time does your child spend being physically active each day? (running, jumping, dancing, etc.)	
Time (Hours)		24. How much time does your child spend each day watching TV/videos, playing computer/gaming systems, on tablet?	
		25. When riding in a car/truck, does your child use a car seat/booster?	
		26. When your child rides a bike/trike, does he/she wear a helmet?	

Child's Name:

Non-Food Allergies

27. Does your child have allergies or severe reactions to any of the following: ☐Yes ☐No If yes, please check only those that apply: ☐**Insect Bites/bee stings*** ☐Animals ☐Pollens/Hay Fever ☐Medications ☐Other (Please Specify)
Please describe your child's allergic reaction:
How do you treat your child's allergy?
Has the allergy been diagnosed by a doctor? ☐Yes ☐No
Child Health Plan Required/Potentially life-threatening condition

Medications

Yes	No	Please answer the following:
		28. Does your child take any medications? Please list ALL medications:
		29. Will your child need to take any medications during scheduled programming? (Staff: Please review Medication Administration Procedure; additional action required)

Dental

Yes	No	
		30. Has your child complained about pain in the teeth or gums? If yes, please describe:
		31. Does your child use fluoride toothpaste at home?
		32. How many times per day does your child brush teeth at home?
		33. Does your child go to bed with a bottle or sippy cup? If yes, what is in the sippy cup? (Staff: provide some education about sitting sugars and tooth decay)
		34. Has your child visited the dentist?

Nutritional Information

Yes	No	Please answer the following:
		35. Is your child receiving services through WIC?
		36. Does your family receive benefits through the SNAP program?
		37. Do you have questions about feeding your child? If yes, Please explain:
		38. Do you have concerns about what your child eats? How many meals _____ and snacks _____ are offered? Please explain:
		39. Do you share meals together as a family? If no, where does your child eat in the home? _____
		40. Does your child drink from a cup?
		41. Does your child drink from a baby bottle?
		42. Do you have any concerns about your child's growth? Please explain:
		43. Do you have any concerns about your child's weight? Please explain:
		44. Does your child take a prescribed iron supplement? Why? How often? Please explain:
		45. Does your child currently use any nutritional supplements (Pediasure, ensure, multivitamins, herbs, etc.)? If yes, which ones, how often, and for what reason:
		46. Does your child eat any nonfood items? (Example: crayons, marbles, paper, etc.). Please list: _____
		47. How would you describe your child's appetite?
		48. Does your child need assistance with feeding self?

Food Allergies, Intolerances, and Preferences

Yes	No	Please answer the following:
		49. Has a medical provider ever told you that your child has a food allergy or intolerance? If yes, please explain: Does your child have an Epi-Pen? **Is this a life-threatening food allergy?***

Child's Name:		
		50. Are there foods that your child cannot eat for cultural/religious reasons? If yes, please list:
If your child has a food allergy or intolerance that has been diagnosed by a doctor, we will ask for documentation from your medical provider that includes a list of foods that can be substituted.		
****Child Health Plan Required/Potentially life-threatening condition***		

List Health and Nutritional Education Resources Shared with Parents

☐ Lead Information

☐ Nutritional Information

☐ Fluoride Information

☐ Other (please list):
(i.e. tobacco cessation, helmet, car seat, safety, other)

Signatures – First Year

Parent:	Date
Staff who reviewed with Parent	Date reviewed with parent
Interpreter (if applicable)	Date:

Signatures – Second Year

Parent:	Date
Staff who reviewed with Parent	Date reviewed with parent
Interpreter (if applicable)	Date:

Child and Adult Care Food Program (CACFP) Enrollment Income Eligibility Application (EIEA)

PART 1 – CHILDREN'S INFORMATION (REQUIRED)

Child's Name	Birthdate	Age	Days of Attendance	Arrival Time	Departure Time	Circle Meals and Snacks Normally Received	Check Below if Foster Child
			Sun Mon Tu Wed Th Fri Sat			Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack	☐
			Sun Mon Tu Wed Th Fri Sat			Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack	☐
			Sun Mon Tu Wed Th Fri Sat			Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack	☐
			Sun Mon Tu Wed Th Fri Sat			Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack	☐

PART 2 – HOUSEHOLD MEMBER RECEIVING BASIC FOOD/TANF/FDPIR IN WA STATE - Any household member receiving benefits can establish eligibility for children in the household. If listing case number or ID, please skip to part 5.

Case Number or ID number

PART 3 – TOTAL HOUSEHOLD GROSS ANNUAL INCOME

The adult signing the form must list the last four digits of their Social Security Number (SSN) or check the box if no SSN. *See Privacy Act Statement and Sources of Income on the back of this page*

(Annual Income Conversion by pay frequency: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12)

List names (First and Last) of everyone in your household, including foster children	Annual Earnings from Work Before Deductions	Annual Welfare, Alimony, Child Support	Retirement, Pensions, Social Security, Other
1.	$ /yr	$ /yr	$ /yr
2.	$ /yr	$ /yr	$ /yr
3.	$ /yr	$ /yr	$ /yr
4.	$ /yr	$ /yr	$ /yr
5.	$ /yr	$ /yr	$ /yr
6.	$ /yr	$ /yr	$ /yr

Number of Household Members		Last 4 of SSN (check box if no SSN)				

PART 4 – CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

We are required to ask for information about your children's race and ethnicity. This information helps to make sure we are fully serving our community. Responding to this section is optional, it will not affect your children's 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
- ☐ Multi-Racial
- ☐ Native Hawaiian or Pacific Island
- ☐ Black or African American
- ☐ Asian
- ☐ White

PART 5 – PARENT/GUARDIAN SIGNATURE AND CERTIFICATION—(REQUIRED) SIGNATURE CONFIRMS ALL INFORMATION PROVIDED IS CORRECT AND ACCURATE

"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."

Signature _____ Print Name _____ Date _____

Address	City, State, Zip	Phone Number

DO NOT FILL OUT – CENTER USE ONLY	CATEGORY		OSPI USE ONLY
_____ _____ Institution Representative Signature Date **INVALID WITHOUT SIGNATURE AND DATE** (see back for effective date requirements)	☐ Free (Basic Food/TANF/FDPIR) ☐ Free (foster child(ren)	Total Annual Income $_____ ☐ Free ☐ Reduced-Price ☐ Above-Scale	☐ Free ☐ Reduced ☐ AS _____ OSPI Rep.

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 Basic Food, 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, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or

FAX: (833) 256-1665 or (202) 690-7442; or

EMAIL: program.intake@usda.gov

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

This institution is an equal opportunity provider.

EIEA Effective Date

If the institution uses the parent/guardian signature date as the effective date, the form must be signed by the institution representative within the same month as the parent, or the following month. If the institution representative does not sign the EIEA within these timeframes, the institution representative's signature date must be used as the effective date.

Valid TANF or Basic Food Number Guidelines and Contact Resources for WA State Recipients

Consists of seven to nine digits, such as 004235555 A parent may omit the zeros preceding the number and write as (ex. 4235555) May start with 002, 003, 004, 005 or 05 Does not include any letters	Is not a social security number (unless it's a tribal case number). Does not start with a 200 series number Is not a case number for state-paid childcare Is not an EBT card number
DSHS Customer Service Number: (877) 501-2233	**Basic Food and TANF website: www.washingtonconnection.org**

Earnings from Work	Public Assistance, Alimony, Child Support	Pension, Retirement, Other Sources of Income	Sources of Child Income	Examples:
• Salary, wages, cash bonuses • Net income from self-employment (farm or business) <u>If you are in the U.S. Military:</u> • Basic pay and cash bonuses (does NOT include combat pay, FSSA, or privatized housing allowances) • Allowances for off-base housing, food, and clothing	• Unemployment benefits • Workers' compensation • Supplemental Security Income • 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	Earnings from work	A child of legal working age 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 any other source	A child receives regular income from a private pension fund, annuity, or trust