# Family Interview Questions Date_____

1. Child's Name:_____
2. Birth Date: _____
3. Parent's/Guardians names: _____
4. Address: _____
5. Parents Email: _____
6. Home Phone #: _____ Cell Phone #: _____

Work Phone #: _____

7. **Will the child be on state pay (Best beginning program)? You must provide us with proof!** Either a letter from your case worker, an email from your caseworker or other form of proof**.**

☐ **YES** ☐ **NO** **(Please check one)**

8. Days: ☐ M ☐ T ☐ W ☐ Th ☐ F or ☐ varies (please check days attending)
9. Ideal Hours needed
10. **Date child will start:**
11. Has your child been in a preschool/childcare setting before?
12. Where did you hear of Kid Kountry CDC:
13. Previous Provider's Name & Phone Number:

Staff enrolling child/children please initial_____

We need the following before your child can start care at Kid Kountry.

Checklist:

- ☐ Immunization records
- ☐ If your child has any allergies, asthma or other special need we need the special needs health care form filled out and signed by a doctor.
- ☐ If your child has asthma, please ask for the correct form to be filled out from the office.
- ☐ Food program sheet must be filled out even if you do not qualify its. It is Federally mandatory
- ☐ Registration fee must be paid
- ☐ Sign and date all forms
- ☐ A calendar from the front desk must be filled out
- ☐ A water bottle for your child
- ☐ Family pictures for preschoolers
- ☐ Extra change of clothes

Kid Kountry CDC requires a family orientation.

This information is presented to you at the time of enrollment, both verbally and written in the parent handbook, which you will be given to take home. Please initial these items and sign this form to acknowledge receipt of this information.
I am acknowledging that I have received a tour of Kid Kountry. I have had the opportunity to ask questions and

- Tour of the center
- Center philosophy, curriculum, holidays, commitment to anti-bias policies
- Center Policy handbook gone through listing all policies.
- Enrollment and admission requirements
- Fees, billing and payment agreements
- Typical activity schedule including hours of operation.
- Menus, substitutions, USDA guidelines, allergies
- Open door policy, pick up people other than parents.
- Sign in and out requirements, electronic Procare system (each adult picking up must have their own #)
- Child abuse law requirements. We are mandated reporters.
- Behavior management discipline policy
- Nondiscrimination statements
- Transportation and fieldtrips (children ages 5 and up)
- Practices concerning ill child, health policies.
- Medical emergencies
- Parent communication policies office/classroom
- Diapering; toilet training
- HIPPA Policies- staff are trained in confidentiality.
- Disaster plan (emergency go kit)- in each classroom.
- Pesticide policy-lice.
- One-month notice policy
- Any and all other paperwork questions asked and answered. Including the childcare contract

If you have questions or concerns please contact Meghan Reser (Director), Lauren Huck (Director) or Kaycee Hodges (Owner)

Family signature_____ Date

Tuition® Express

# *Automated Payment Processing*
## *Safe – Convenient – Easy*

Payment date
Please circle date or dates you would like payments pulled each month
1st, 5th, 15th or 20th

We are excited to offer the safety, convenience and ease of Tuition Express® – a payment processing system that allows on-time tuition and fee payments to be made from either your bank account or credit card.

**ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD**

I (we) hereby authorize (business name) _____**to initiate credit card charges to the below referenced credit card account (Section A) OR, initiate debit entries to my (our) Checking or Savings Account, indicated below (Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit Union Members: Please contact your Credit Union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

**COMPLETE ONE SECTION ONLY**

**SECTION A (Credit Card)**

Cardholder Name Phone #

Cardholder Address City State Zip

Account Number Expiration Date

Cardholder Signature Date

**SECTION B (Bank Account)**

Your Name Phone #

Address City Zip State

Bank or Credit Union Name

Bank or Credit Union Address City State Zip ☐ Checking ☐ Savings

Routing Transit Number (see sample below) Account Number (see sample below)

**For Official Use Only**

| |
|---|
| **Date Received** |
| **Employee Signature** |


**A service of**

procare SOFTWARE®

Convenient and Safe On-time Payments

Procare SOLUTIONS

# Frequently Asked Questions by Parents

We are excited to offer automatic payments through Tuition Express. With this service, it is no longer necessary for you to write a check for tuition and fees. Payments will be automatically deducted from a debit or credit card, or your bank account. All payments are secure, and you can even choose to have a receipt emailed to you after each transaction. It's easy to sign up, just ask your childcare provider.

## When I pay my tuition automatically, how secure is my account information?

Very secure—more secure than when you write checks. The checks you write every day have your name, address, phone number and sometimes your driver's license number on them. With this information, criminals have all they need to access your account, or worse, steal your identity. Automatic payments greatly reduce this potential by limiting the amount of information available and the number of people who have access to it. Tuition Express also incorporates additional security procedures, utilizing 256-bit encryption.

## What if my childcare center and I disagree about a payment?

If you feel that a payment should not have been made, please contact your childcare provider at your earliest convenience. They can work with you to help resolve the matter by adjusting your account or look at refund options for you.

## How will I know when a payment is taken out of my account?

Your childcare expenses will be taken out of your account on a schedule that you and the childcare center agree upon. Your childcare center can print statements for your records, prior to the withdrawal of any money. Payments made electronically will post to this statement with the Tuition Express label. Statements issued through your bank or credit card provider will display the name of your childcare center for debited transactions.

## When I sign up for Tuition Express, how will this help my childcare provider?

Your childcare provider has chosen to offer automatic payments for several reasons. First, it will give you the convenience of not having to write a check every time tuition and fees are due, enabling a touchless way to pay. Second, it allows regular scheduling of your payments. Third and most importantly, automatic payments reduce the amount of time your childcare provider spends on administrative tasks, giving staff more time to spend with the children.

## How do I get started?

Simply complete the "Payment Authorization" form and return it to your childcare provider. They will do the rest!

## Where do I go if I have questions about a transaction on Tuition Express?

Should you have a question about a Tuition Express transaction that your childcare provider has processed,it is important that you contact them directly to discuss your issue. Tuition Express cannot work directly with parents on transaction matters due to security and privacy policies. However, your center can contact Tuition Express on your behalf, and we will assist them with transaction questions and concerns. If the childcare provider makes a mistake and takes out too much money, report the error immediately—it was likely an honest mistake. The childcare provider will adjust your account accordingly.

I understand that,

My childcare position will be considered open and available to others until the following criteria have been met: A signed contract indicating a start date, and payment in full for the registration fee and first month payment. Positions will not be held for more than two weeks beyond the signed contract date. No money will be refunded in case of default by the parent(s). Fees are per child and are non-negotiable. There is a one-month mandatory notice which must be given otherwise the full amount is due for child care period normally scheduled. This notice must be in writing.

***$100 registration fee per family, then a yearly supply fee of $50 per child or $75 per family every April***

**Paid Holidays and absences:**

The following are paid holidays when they fall on a regular work weekday M-F:
Memorial Day, Labor Day, Thanksgiving Day, the day after Thanksgiving, New Year's Eve Day, New Year's Day, Christmas Eve, Christmas day and the day after (depending on the calendar year). The Fourth of July or the day in observance and the day after, Halloween early closure. We will have one random day for training during the year. A 2 week notice will be given to find alternative care for that day. These are the ONLY days the center is closed. Some of these holidays, depending on the year, we are not closed. You will be notified beforehand. Charges for a child's absence for an illness or vacation are part of your set fee, which does not change.

**State pay Best Beginnings families:**

***Your state pay must be showing in the system attached to our facility within 15 days or we MUST receive a call from your caseworker saying you are qualified WITHIN 15 days. If this does not happen, you must be making payments until you are qualified. We will refund any payments made that the state later covers. Your payment will be determined based on estimated co-pay (see office).***
If you are a Best Beginnings (state pay and foster) family, you are required to pay your co-pay in advance, and you must attend 85% of your monthly authorization days. Fulltime is 22 days this means they must be here 18 days a month. The state no longer covers CE days (sick days) so if your child is not meeting their 85 % you will be charged the daily rate of $40. Any questions please see Lauren

By signing this form, I understand that these rates can change, I agree to all fees and criteria above. I will be notified of any rate changes.

Parent/ Guardian Signature_____ Date: _____

## Rates:

### Ages 2-5 not yet in kindergarten

| | |
|---|---|
| **Full time care** Toddler Class 2-3 (not potty trained) | $990 per month |
| **Full time care** Preschool Class 3-4 (3+ AND potty trained) | $880 per month |
| **Full time care** Pre-Kinder Class 4-5 | $880 per month |
| **Part time care** 8:30 am to 12:30 pm only | $560 per month |
| **Part time** 12 days a month | $600 per month |

### School age children Ages 6-12

AM transportation & care only $220 per
AM&PM transportation & care month $560
(Includes PIR/all days off school) per month
Summer camp Full time care $805 per month

$75 field trip fee each month per child. This includes Best Beginnings families and foster families
(must commit to 3 months of summer camp)

## *Payment options Per transaction*

Payment by Tuition express ACH (out of checking/saving ) FREE
Payment by Tuition express Credit/Debit card auto payments 2.8%
Payment by Tuition express Credit card POS "swiping card" 2.8%

| | |
|---|---|
| Payment by Check | $10 |
| Payment by Money Order | $10 |

| Other Fees | | Per transaction |
|---|---|---|
| Declined CC payment | $35 | No call no show fee $10 |
| Declined ACH payment | $35 | Returned check $35 |
| Credit card refund | $20 | Changing payment date |

Payment by agency (state pay Best Beginnings) no charge.

Late fee if paying by cash or check $100 if not paid by the 5th/20th
Up to $200 per month.

If your tuition is late two times in a six-month period, you MUST be put on automatic payments.

Child's name: _____

Please check your choice

1 I Do ☐ Do Not ☐ Give permission for my child to go on field trips with Kid Kountry CDC.

2. I Do ☐ Do Not ☐ Give permission for my child to be preschool assessed.

3. I Do ☐ Do Not ☐ Give permission for my child to be photographed (Stills) to display on bulletin boards or to show current/perspective clients

4. I Do ☐ Do Not ☐ Give permission for my child to be photographed to display photos on Kid Kountry website/Facebook page

I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment. By filling this form by PDF I am verifying this as my signature.

*Signed: _____Date_____ (Parent or Guardian signature, and date)*

---

## ***Client Information sheet***

Name: _____Spouses or another guardian's name: _____

Physical Address: _____ Mailing Address: _____

Home Phone: _____Work Phone: _____

SS#: _____ OR DL#: _____

Bank Reference: _____

Employer: _____ Credit Card: _____

I understand that I am Responsible to Kid Kountry for payment for any charges incurred by myself or my spouse. An interest charge of .08% per month will be charged (time past due) and a rebilling fee of $5.00 per month. Delinquent account over 30 days will be sent to collections, and the consumer will be responsible for reasonable collections / attorney fees over and above the account balance plus interest. I understand that until this balance is paid, all further transactions with Kid Kountry will be paid at the time of service.

I, the undersigned, acknowledge the credit terms outlined above. By filling this form by PDF I am verifying this as my signature.

Signature_____Date_____

---

## ***School age form***

## ***(Please only fill out this section if you have a school age child)***

It is very important to have the ***exact*** times that your child needs to be dropped off and picked up.

CHILDS NAME: _____SCHOOL: _____

DATE SCHOOL STARTS: _____

TIME TO BE DROPPED OFF AT ELEMENTARY SCHOOL: _____ GRADE: _____

TIME TO BE PICKED UP AT ELEMENTARY SCHOOL: _____

Days that I will need transportation: Please checks day needed

M ☐ T ☐ W ☐ TH ☐ F ☐

I give permission for Kid Kountry to pick my child up from school. I understand that Kid Kountry has many schools to transport to and may occasionally be late to pick up my child.

The following policies are in place for the school age program:

Morning transportation is optional, and you do NOT need to call if your child will not be coming in the morning.
Your child MUST be here by 7:15 am for breakfast and the vans leave the parking lot at 7:30am.
You MUST call before 2pm if your child will not be attending the afterschool program. *We have a no call no show fee of $10 per day that will be added to your bill. The purpose for this policy is to eliminate unnecessary driving and waiting at schools where children don't show. It also makes us late to other schools as our teachers cannot leave a school where a child is unaccounted for. Please inform your child's school that they will be attending Kid country CDC.* By filling out this form by PDF I am verifying this as my signature.

SIGNATURE: _____DATE: _____

**Individualized Personal Care-plan for Preschool age children** Parent **desires and family values…**

Childs name: _____ Date of BIRTH_____

What would you like us to call your child?_____

**Developmental History**

| | | | | | |
|---|---|---|---|---|---|
| Hears well | Yes ☐ | No ☐ | Vision ok? | Yes ☐ | No ☐ |
| Talks like other children | Yes ☐ | No ☐ | Recent medical problems? | Yes ☐ | No ☐ |
| Walks runs& climbs like others | Yes ☐ | No ☐ | Other concerns? | Yes ☐ | No ☐ |
| Family history of hearing impairments? | Yes ☐ | No ☐ | | | |

Please explain any of the above concerns here:

_____

_____

_____

**Family information**

Who does the child live with:

Who else lives in the home:

Language Spoken at home:

Any words or phrases in home language we should know?

Are there cultural or family customs, rituals or traditions that we should know?

**Health Development**

Describe any serious illness or hospitalizations:

Special needs diagnosed?

Receiving any special services?

Regular medications?

**Eating routine**

Food allergies?

Eating issues?

Problems with: diarrhea ☐ constipation ☐

Used at home: potty chair ☐ special seat ☐ regular seat ☐

Words used for urination_____

Bowel movements_____

Does child have accidents? _____

**Comforting/distress**

Does your child have a security object?_____

Other information_____

**Toileting and dieting habits**

| | | |
|---|---|---|
| Is your child toilet trained | YES ☐ | NO ☐ |
| Are bowel movements regular | YES ☐ | NO ☐ |

**Sleep routine**

Does your child sleep in ☐ Bed ☐ family bed other?_____

Rest routines

Typical length of rest

Waking behavior/routine

What time does child go to bed at night?

**Separation**

Has child been left in care of someone else?

Ways to calm your child?

What difficulty does your child have separating from you?

What can we do to help you and your child feel more comfortable?

**Social relationships**

Experienced playing with other children? ☐ YES ☐ NO

How would you characterize your child? Friendly ☐ Aggressive ☐ Shy ☐ Withdrawn ☐

Child prefers to play: ☐ alone ☐ in small groups

Fears of child: ☐ animals ☐ rough children ☐ loud noises ☐ dark

What is your style of guidance/discipline?

What ideas do you have about parenting that would help us to better care for your child?

What do you as a family hope to get out of this preschool/childcare experience?

Parent signature: _____Date_____

Staff signature: _____Date_____

DPHHS-QAD/CCL-113
(Revision 7-2006)

State of Montana
Department of Public Health and Human Services
Quality Assurance Division – Licensure Bureau
Child Care Licensing

# EMERGENCY CONTACT AND PARENTAL CONSENT

**THIS FORM MUST BE TAKEN WITH THE CHILD WHEN EMERGENCY MEDICAL CARE IS NEEDED.**

**Child's Name:**_____ **Birth Date:**_____

**Address:**_____

**Mother / Legal Guardian's Name:** _____ **Home Number:** _____

**Address:** _____ **Cell Number:** _____

**Work Address:**_____ **Work Number:**_____

**Father / Legal Guardian's Name:** _____ **Home Number:** _____

**Address:** _____ **Cell Number:** _____

**Work Address:**_____ **Work Number:**_____

**Emergency Contact Person:** _____ **Contact Number:** _____

**Emergency Contact Person:** _____ **Contact Number:** _____

**Physician / Medical Care Source:** _____ **Contact Number:** _____

**Health Insurance Carrier & Policy Number:** _____

**Persons authorized to pick up child:**

**Name:** _____**Name:** _____

**Name:** _____ **Name:** _____

**– SEE REVERSE SIDE**

## WRITTEN CONSENT IS GIVEN FOR:

☐ Yes ☐ No EMERGENCY MEDICAL CARE

☐ ADMINISTRATION OF PERSCRIPTIONS MEDICATIONS **Medication Authorization form and Medication Administration Log Must be completed**

☐ ADMINISTRATION OF NON-PERSCRIPTIONS MEDICATIONS **OTC Medication Authorization form and Medication Administration Log Must be completed**

☐ ADMINISTRATION OF SPECIAL DENTAL OR DIETARY NEEDS:

Please Specify:

☐ TRIPS: ☐ Yes ☐ No TRANSPORTATION BY THE FACILITY FOR TRIPS

☐ Yes ☐ No DAILY TRANSPORTATION PROVIDED BY THE FACILITY (Facility Has the Option to Offer)

IF YOUR CHILD IS TRANSPORTED BY THE FACILITY, ARE THERE ANY INSTRUCTIONS FOR SPECIAL CARE FOR THE CHILD (I.E. MOTION SICKNESS, SEIZURES, ECT.) DURNG TRANSPORTATION?

## HEALTH HISTORY

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Hay fever, Asthma, or Wheezing | ☐ | ☐ | Chicken Pox | ☐ | ☐ |
| Eczema or Frequent skin rashes | ☐ | ☐ | Diabetes | ☐ | ☐ |
| Convulsions/Seizures | ☐ | ☐ | Trouble with passing urine/ bowel | ☐ | ☐ |
| Heart Condition | ☐ | ☐ | Frequent colds, sore throats, Earaches, Tonsillitis, Pneumonia | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| **Allergies or reactions: (food or other)** | ☐ | ☐ |

Please Explain :

| | YES | NO |
|---|---|---|
| **Other Health Concerns (special disabilities):** | ☐ | ☐ |

Please Explain:

**SIGNATURE OF PARENT OR GUARDIAN** **DATE**

# NON-INGESTIBLE OVER THE COUNTER MEDICATION AUTHORIZATION FORM

**TO BE COMPLETED BY PARENT**

Child's Name _____ Date of Birth ____/___/____

Program Name Kid Kountry CDC

**********

**I give permission for the administration of the following non-ingestible over the counter medications (mark all that apply):**

- ☐ Diaper Rash Cream/ointments_____
- ☐ Insect Repellent_____
- ☐ Sunscreen_____
- ☐ Cortisone/Anti-Itch Creams/Ointments_____
- ☐ Medicated Lip Treatments_____
- ☐ OTC Antibiotic Creams/Ointments_____
- ☐ Burn Creams/Sprays_____
- ☐ Other Non-Ingestible OTC's: (Please Specify)_____

_____

_____

To administer a non-ingestible over the counter medication:

- The medication must be brought to the day care facility from the parent
- The medication must be in its original container, with a legible label, and expiration date of medication;
- The child's name must be on the original container

Special handling/storage Instructions_____ Refrigeration?_____

**Parent/Guardian Signature** (required) _____ Date:_____/_____/____

*** This document must be updated on an annual basis.**

**Unused Medication:** (check one) Returned to Parent Y N Discarded appropriately Y N

**By:**_____ **Date:**_____/_____/_____

*** Keep in the child's file when medication is finished.**

# SPECIAL NEEDS HEALTH CARE PLAN

***-To be approved by a Health Care Provider-***

| Today's Date |
|---|

| Child' Full Name | Date of Birth |
|---|---|
| Parent's/Guardian's Name | Telephone No. |
| Primary Health Care Provider | Telephone No. |
| Specialty Provider | Telephone No. |
| Specialty Provider | Telephone No. |

Diagnosis(es)

Allergies

## ROUTINE CARE

| Medication To Be Given at Child Care | Schedule/Dose (When and How Much?) | Route (How?) | Reason Prescribed | Possible Side Effects |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

List medications given at home:

## NEEDED ACCOMMODATION(S)

Describe any needed accommodation(s) the child needs in daily activities and why:

Diet or Feeding:_____

Classroom Activities:_____

Naptime/Sleeping:_____

Toileting:_____

Outdoor or Field Trips:_____

Transportation:_____

For Behavior Changes:_____

Additional Comments:_____

_____

## SPECIAL EQUIPMENT / MEDICAL SUPPLIES

1.
2.
3.

## EMERGENCY CARE

**CALL PARENTS/GUARDIANS** if the following symptoms are present:

**CALL 911 (EMERGENCY MEDICAL SERVICES)** if the following symptoms are present, as well as contacting the parents/guardians:

**TAKE THESE MEASURES** while waiting for parents or medical help to arrive:

## SUGGESTED SPECIAL TRAINING FOR STAFF

| Health Care Provider Signature | Date |
|---|---|

## PARENT NOTES (OPTIONAL)

_____

_____

_____

Parent/Guardian Signature Date

**Important:** *In order to ensure the health and safety of your child, it is vital that any person involved in the care of your child be aware of the child's special health needs, medication your child is taking, or needs in case of a health care emergency, and the specific actions to take regarding your child's special health needs.*

# STATE OF MONTANA— CHILD CARE FACILITY/SCHOOL CERTIFICATE OF IMMUNIZATION

**Complete immunization requirements and penalties for those who fail to meet the requirements are referenced in Section V. This form is required for ALL persons attending school or child care. See the reverse side for information about EXEMPTIONS and INSTRUCTIONS.**

## SECTION I *PLEASE PRINT CLEARLY*

| Child/Student's Name | Birth Date | Sex | Primary Provider | |
|---|---|---|---|---|
| | | | | |
| **Name of Parent/Guardian** | **Address** | | **City** | **Telephone**<br>**Home**<br><br>**Work** |
| | | | | |

## SECTION II IMMUNIZATION HISTORY

**Valid only when filled out by School, Child Care or Medical Personnel (NOT to be filled out by the parent).**

| **Required Vaccines**<br>(CC= Child Care Requirement; SR=School Requirement) | **Month, Day & Year of Each Dose**<br>**1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|---|
| **Diphtheria/Tetanus/Pertussis (DTaP)** | | | | | |
| **Booster Dose Tdap required prior to 7th grade entry** | | | | | |
| **Haemophilus Influenzae Type B (Hib)**<br>**(Only children less than 5 years)** | | | | | |
| **Measles/Mumps/Rubella (MMR)**<br>**or** | | | | | |
| **Measles vaccine only** | | | | | |
| **Mumps vaccine only** | | | | | |
| **Rubella vaccine only** | | | | | |
| **Polio (IPV or OPV)** | | | | | |
| **Varicella (Chickenpox) [VZV or VAR]**<br>**Check here if child has documentation of disease** | | | | | |

| **ACIP* Recommended Vaccines**<br>*Advisory Committee on Immunization Practices,<br>U.S. Centers for Disease Control and Prevention | **Month, Day & Year of Each Dose**<br>**1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|---|
| **Hepatitis A** | | | | | |
| **Hepatitis B** | | | | | |
| **Human Papillomavirus (HPV) - for adolescents** | | | | | |
| **Influenza- recommended annually for all over 6 mos.** | | | | | |
| **Meningococcal Conjugate Vaccine (MCV4) (Ages 11-12 & later)** | | | | | |
| **Pneumococcal Conjugate vaccine (PCV)** | | | | | |
| **Rotavirus** | | | | | |

**NOT A COMPLETE IMMUNIZATION RECORD- CONTACT YOUR PROVIDER OR PUBLIC HEALTH AGENCY FOR MORE INFORMATION**

**If filled out by health department or health care provider:**

To the best of my knowledge, this child has received the above immunizations.

Signed: _____
*(Health Department/Health Care Provider) Date*

Signed: _____
*(Health Department/Health Care Provider) Date*

Signed: _____
*(Health Department/Health Care Provider) Date*

Signed: _____
*(Health Department/Health Care Provider) Date*

**If filled out by school or child care personnel:**

I CERTIFY this information has been transferred from supporting documentation as stated in the Administrative Rules of Montana:

Signed: _____
*(School or Child Care Official and title)* *Date*

Signed: _____
*(School or Child Care Official and title)* *Date*

Signed: _____
*(School or Child Care Official and Title)* *Date*

Signed: _____
*(School or Child Care Official and Title)* *Date*

## SECTION III INSTRUCTIONS

### Health Department or Physician

1. For medical exemption purposes, a physician is a person licensed to practice medicine in any jurisdiction of the U.S. or Canada. This does not include chiropractic or naturopathic doctors, nurse practitioners or physician assistants.
2. In Section II, please include vaccine doses with month, day and year for each administered dose. Immunization dates, as specified in the administrative rules, are necessary. Please sign and date the form.
3. **If the child is completing a vaccine series,** a Conditional Attendance form can be used. The physician or health department will determine the date of each dose to be administered and put the schedule on the Conditional Attendance form. Please sign the Conditional Attendance form, and return to the school or child care facility.
4. Immunization forms can be obtained directly from the local health department or the Montana Immunization Program at immmunization.mt.gov.

### School and Child Care Official

**1. Prior to attending**, all students and child care facility attendees must have either **a)** the required immunizations **and documentation** or **b)** have completed the appropriate exemption or conditional attendance documentation. This includes transfer students.
**2. Documentation** must meet the criteria of the Administrative Rules of Montana. This is **limited** to other school health records and certain documents from health departments and physicians.
**3. Transferring information from supporting documentation to this form** must be done by a school or child care official. The school or child care official must then sign and date the form (Section II) and attach the supporting documentation.
**4. Conditional Attendance** form, once completed and attached to this document, allows attendance so long as immunization continues as scheduled.
**5. School Transfer Students**.

**There is no transfer period allowed.** Transfer students must provide adequate documentation of immunization **PRIOR** to attending school.

**a) Transferring In:** Students who transfer into Montana from out of state must have their immunization information recorded on this form (*See number 2 above regarding acceptable documentation.)* Students must meet Montana immunization requirements.
**b) Transferring Out:** If students transfer out of your school, a **copy** of this record should be maintained for one year following the transfer. The Montana law requires schools to forward the original Certificate of Immunization to the school to which students transfer.
**c) Homeless Students:** All homeless students must be immediately enrolled in a Montana school to ensure compliance with the McKinney-Vento Act. Students should be assigned a liaison who can assist them in obtaining either appropriate documentation of immunization or in obtaining the required immunizations.

### Parent

1. Montana law requires immunization information be recorded on this document for persons to attend Montana schools, preschools and child care facilities.
**2. ONLY school, child care and health officials can complete this form.** School and child care officials need documentation from physicians or health departments as described by the Administrative Rules of Montana (*examples: A completed Montana Certificate of Immunization; A signed Immunization record card).* **It is the parent's responsibility to provide these documents to the school or child care facility.**
**3. Religious exemption and conditional attendance** may be used in accordance with the Immunization Law and Administrative rules. The Religious Exemption may be used in school settings and must be renewed annually. Religious exemption for child care only applies to Haemophilus influenzae type b (Hib), and must be renewed annually.
4. Montana law prohibits children from attending any Montana school or child care facility **prior** to meeting immunization requirements.
5. If your child transfers to another Montana school, a copy of this completed form will allow your child to enter that school. However, the original Certificate of Immunization must be provided to the new school within 30 days of transfer in order for the child to attend.

## SECTION IV EXEMPTIONS

Please refer to the form HES101A at
immunization.mt.gov

## SECTION V LEGAL REFERENCES

**Montana Codes Annotated**
20-5-101 - 410: Montana Immunization Law
52-2-735: Day Care Certification

**Administrative Rules of Montana**
37.114.701-721: Immunization of K-12, Preschool and Post secondary Schools
37.95.140: Day Care Center Immunizations
Group Day Care Homes – Health
Family Day Care Homes – Health

If you have any questions about: 1) the use of this form; 2) obtaining copies of immunization forms, laws, or rules; or 3) whether or not a person meets attendance requirements, please contact your local health department or the Montana Immunization Program, DPHHS, Cogswell Building, Helena, MT 59620. Phone (406)444-5580.

**www.immunization.mt.gov**

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Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. This child care center 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 child 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 your child care center.

**2. Who can get free meals without providing income information?** Children in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Food Distribution Program on Indian Reservations (FDPIR), or Temporary Assistance for Needy Families (TANF) can get free meals. Foster children and children enrolled in Head Start are also 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 Eligibility Guidelines.

**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 Income Eligibility Guidelines 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, FDPIR, or TANF 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 your child care center director.

**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.

**10. *(Pricing program only)* Will the information I give be verified?** Maybe. We may ask you to send written proof to verify the information you submitted on the form. **What if I disagree with the decision about the information I complete on this form?** You should talk to your child care center.

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 your child care center. Sincerely, Kid Kountry

# CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

**Institution or Facility Name:** Kid Kountry CDC

**Part 1. Name of Child(ren) Enrolled:**

| | | |
|---|---|---|
| | | CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT)<br>* IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM. |
| | | |
| | | |
| | | |
| **Full names of all household members** | | |
| | | |
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| | | |
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| | | |

**Part 2. Benefits:** If any member of your household received [SNAP], [FDPIR] or [TANF 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, a migrant, or a runaway, call the State agency for instructions.

**Part 4. Total Household Gross Income—You must tell us how much and how often (whole dollar amounts, please)**

| Total number in household: _____ | **B. Gross income and how often it was received** *(if $0, please write $0. Any field left blank will be accepted as representative of "no income"* | | | |
|---|---|---|---|---|
| **A. Name**<br>(List **only** household members with income) | 1. Earnings from work before deductions | 2. Welfare, child support, alimony | 3. Pensions, retirement, Social Security, SSI, VA benefits | 4. All other income |
| *(Example)*<br>*Jane Smith* | $200/weekly | $150/twice a month | $100/monthly | $_____ /_____ |
| | $_____/ | $_____/ | $_____/ | $_____/ |
| | $_____/ | $_____/ | $_____/ | $_____/ |
| | $_____/ | $_____/ | $_____/ | $_____/ |
| | $_____/ | $_____/ | $_____/ | $_____/ |
| | $_____/ | $_____/ | $_____/ | $_____/ |

**This section required for all forms listing income in Part 4:**

Last four digits of Social Security Number: X X X - X X - __ __ __ __ ❑ I do not have a Social Security Number

**Part 5. Signature (Adult must sign)**

An adult household member must sign this form.

*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:

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

| Mark one ethnic identity: | Mark one or more racial identities: |
|---|---|
| ☐ Hispanic or Latino<br>☐ Not Hispanic or Latino | ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American<br>☐ White ☐ Native Hawaiian or Other Pacific Islander |

**Part 7. Decline to provide information**

I choose not to provide information about my household size and income.

Signature of Adult Household Member Date

*****This Section is to be completed by the Child Care Institution – Determination of Eligibility*****

***Completion of this section is <u>required</u> for the institution to claim meals at the free or reduced rate for the child/children listed in Part 1: Name of Child(ren) Enrolled.***

Number of persons in the household: _____

Total income $ _____ Per: ❑Week ❑Every 2 Weeks ❑Twice A Month ❑Month ❑Year
(Annual Income Conversion: weekly x 52, every 2 weeks x 26, twice a month x 24, monthly x 12)

Categorical Eligibility: ❑Free ❑Reduced ❑Paid ❑Tier I ❑Tier II

**Required**: Determining Official's Signature: _____ Date: _____

*Additional official signatures are recommended but not required.*

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date: _____

**Privacy Act Statement:** The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve 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), Food Distribution Program on Indian Reservations (FDPIR), or Temporary Assistance for Needy Families (TANF) case number for the participant 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, SW, Washington, D.C. 20250-9410; (2) Fax: (202) 690-7442; or (3) Email: program.intake@usda.gov. This institution is an equal opportunity provider."

**Head Start:** Children who are enrolled in the Federal Head Start Program receive meal benefits in the CACFP without further application or eligibility determination. Acceptable documentation includes a current approved Head Start application or a written, signed and dated statement or roster from a Head Start official. [USDA Memos CACFP 7-2008 and CACFP 10-2008]