United Methodist
Community House

Increasing everyone's ability to succeed in a diverse community.

Child Development Center Application

Programs:
6 Weeks to 5 Years Old

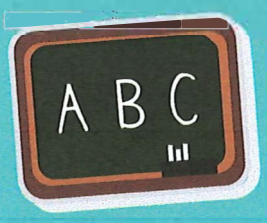
- 4 STAR QUALITY RATING
- HIGH SCOPE CURRICULUM
- NUTRITIOUS MEALS & SNACKS PROVIDED
- FAMILY ENGAGEMENT ACTIVITIES

Required Documentation:

-COMPLETED APPLICATION
-HEALTH APPRAISAL
-CHILD'S BIRTH CERTIFICATE
-IMMUNIZATION RECORDS

**Enrollment is on a first come-first serve basis.*

For more information please visit our website: umchousegr.org or call 616.452.3226



904 Sheldon Avenue, SE Grand Rapids MI, 49597

United Methodist Community House

Increasing everyone's ability to succeed in a diverse community.

Child Development Center

Tuition Rates
Effective September 2021

United Methodist House offers full-time rates only; we do not offer part time or hourly rates. Children can attend up to 45 hours a week. Hours required above 45, must have approval. Program hours are 7:00 AM-5:30 PM.

Infants **Rooms 101 and 102**

Weekly Rates:	**Full-time =Up to 45 hrs**	**$250.00**
	46 plus	**$275.00**

Toddlers **Rooms 201 and 202**

Weekly Rates:	**Full-time = Up to 45hrs**	**$200.00**
	46 Plus	**$225.00**

Early Pre-school **Room 301**

Weekly Rates:	**Full-time = Up to 45hrs**	**$185.00**
	46 Plus	**$200.00**

Pre-School **Room 302**

Weekly Rates:	**Preschool Only (8:30 3:30)**	**$100.00**
	Preschool Plus Before/After Care	**$175.00**

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Application for Enrollment

Child Development Center (CDC)

Today's Date:_____/_____/_____ First Day of Service: _____/_____/_____

Program Service: ☐ Room 101 ☐ Room 102 ☐ Room 201 ☐ Room 202 Gender (Child): ☐ M ☐ F

☐ Room 301 ☐ Room 302 ☐ Room 303 ☐ Room 304 Age (Child):_____

Name of Child: _____ Birth Date: _____/_____/_____
Last First MI Initial Month Day Year

Address (Child): _____
Street Apt. City State Zip Code

Name (Mother): _____ Birth Date: _____/_____/_____
Or Primary Guardian Last First MI Initial Month Day Year

I am the: ☐ Biological Mother ☐ Adoptive Mother ☐ Step Parent ☐ Legal guardian ☐ Foster Parent

Marital Status: ☐ Married ☐ Domestic Partners ☐ Cohabitating ☐ Separated ☐ Divorced

☐ Address Same as Child

Home Address: _____
Street Apt. City State Zip Code

Telephone Number(s): ( ) _____ H ( ) _____ W

( ) _____ C ( ) _____ Other

E-Mail Address: _____

Place of Employment: _____ What is your title? _____

Name (Father): _____ Birth Date: _____/_____/_____
Last First MI Initial Month Day Year

☐ Address Same as Child

Home Address (if different): _____
Street Apt. City State Zip Code

Telephone Number(s): ( ) _____ H ( ) _____ W

( ) _____ C ( ) _____ Other

E-Mail Address: _____

Place of Employment: _____ What is your title? _____

Marital Status: ☐ Married ☐ Domestic Partners ☐ Cohabitating ☐ Separated ☐ Divorced

Ethnic Background (Child): _____

Other children in the household (other than child(ren) enrolled):

Child's Name	Date of Birth	Gender (M/F)
1)	/ /	
2)	/ /	
3)	/ /	
4)	/ /	

Have you previously enrolled children in UMCH programs? ☐ Yes ☐ No If yes, when? _____

What Program(s) _____ How long were they enrolled?_____

Has your family been enrolled in WIC services within the last 30 days? ☐ Yes ☐ No

Has your family ever been involved with services at Family Promise? ☐ Yes ☐ No

If so, which program(s): _____

Insurance Provider: ☐ Medicaid ☐ Medicare ☐ Private Insurance ☐ Uninsured

Please check the appropriate box for the information below:

Mother's Education

- ☐ Less than High School
- ☐ High School / GED
- ☐ Vocational/Technical
- ☐ College Graduate
- ☐ Graduate

Mother's Employment Status

- ☐ 35 Hours or More per Week
- ☐ Less than 35 Hours per Week
- ☐ Attending College Classes
- ☐ Not in Labor Force
- ☐ Looking for Work

Mother's Income

- ☐ Below $5,000
- ☐ $5,000 - $7,000
- ☐ $7,500 - $9999
- ☐ $10,000 - $14,000
- ☐ $15,000 - $19,999
- ☐ $20,000 - $29,000
- ☐ $30,000 - $39,999
- ☐ $40,000 - $49,999
- ☐ More than $50,000

Please check the appropriate box for the information below:

Father's Education

- ☐ Less than High School
- ☐ High School / GED
- ☐ Vocational/Technical
- ☐ College Graduate
- ☐ Graduate

Father's Employment Status

- ☐ 35 Hours or More per Week
- ☐ Less than 35 Hours per Week
- ☐ Attending College Classes
- ☐ Not in Labor Force
- ☐ Looking for Work

Father's Income

- ☐ Below $5,000
- ☐ $5,000 - $7,000
- ☐ $7,500 - $9999
- ☐ $10,000 - $14,000
- ☐ $15,000 - $19,999
- ☐ $20,000 - $29,000
- ☐ $30,000 - $39,999
- ☐ $40,000 - $49,999
- ☐ More than $50,000

Why have you chosen to enroll your child(ren) at UMCH?

- ☐ Affordability
- ☐ Location of Center is Close to My Job
- ☐ Location of Center is Close to Child's School
- ☐ Clean, Safe, Stimulating Programs
- ☐ Quality of Staff and Programs

How did you hear about UMCH?

- ☐ Referred by a Friend
- ☐ Church Bulletin
- ☐ UMCH Website
- ☐ Referred by Current Student
- ☐ Flier Posted in Neighboring School
- ☐ Social Media

Are you interested in/willing to serve on a Parent Engagement group? ☐ Yes ☐ No

Please read the statements below carefully and indicate your agreement by checking the appropriate box(es) and signing where indicated.

☐ The United Methodist Community House has my permission to use my child's/children's photographic image in any agency Newsletter or other publication that will benefit, promote, or support the mission of the United Methodist Community House.

☐ I have received a full copy of the Parent Handbook of the United Methodist Community House's Child Development Center and have had the opportunity to ask questions or state concerns regarding UMCH policies.

☐ I certify that all of the information provided by me in this application is true and correct.

☐ I agree that I will provide updated income, emergency contact and care information, and other relevant information for my child's record when such changes occur.

_____ _____

Signature of Parent/Guardian Date

HEALTH APPRAISAL

Dear Parent or Guardian: The following information is requested so that the school can work with the parent to meet the physical, intellectual and emotional needs of the child. Fill out the information requested in Section I. Section III may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse and dentist. (**BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION**.)

PERSONAL

CHILD'S NAME (Last, First, Middle)			DATE OF BIRTH (mm/dd/yy)
			/ /
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	TODAY'S DATE (mm/dd/yy) / /
PARENT/GUARDIAN (Last, First, Middle)			HOME TELEPHONE NUMBER ( )
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	WORK TELEPHONE NUMBER ( )

SECTION I - HEALTH HISTORY

Yes	No	Resolved	# Is your child having any of the problems listed below?
☐	☐	☐	1 Allergies or Reactions (for example, food, medication or other)
☐	☐	☐	2 Hay Fever, Asthma, or Wheezing
☐	☐	☐	3 Exzema or Frequent Skin Rashes
☐	☐	☐	4 Convulsions/Seizures
☐	☐	☐	5 Heart Trouble
☐	☐	☐	6 Diabetes
☐	☐	☐	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)
☐	☐	☐	8 Trouble with Passing Urine or Bowel Movements
☐	☐	☐	9 Shortness of Breath
☐	☐	☐	10 Speech Problems
☐	☐	☐	11 Menstrual Problems
☐	☐	☐	12 Dental Problems: Date of Last Exam / /
☐	☐	☐	Other (please describe): _____
☐	☐		Does your child take any medication(s) regularly?
Reason for Medication			

Birth History:

Are there any current or past diagnosis(es) ☐ Yes ☐ No

If yes, please describe:

If yes, list medications:

_____ / / Was the health history reviewed by a health professional?

Parent/Guardian Signature Date ☐ Yes ☐ No ***Examiner's Initials:*** _____

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	VISION	Visual Acuity			
			Muscle Imbalance			
		Date: / /	Other:			
☐	☐	HEARING	Audiometer			
			Other:			
		Date: / /				
☐	☐	URINALYSIS	Sugar			
			Albumin			
		Date: / /	Microscopic			
☐	☐	BLOOD LEAD LEVEL	Level _____ ug/dl ⇨			
		Date: / /				

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	HEIGHT & WEIGHT	Height			
			Weight			
		Other: _____	Other			
☐	☐	HEMOGLOBIN / HEMATOCRIT	⇨			
☐	☐	BLOOD PRESSURE	Reading: _____			
☐	☐	TUBERCULIN	Type: _____			
		Date: / /	Neg.: ☐ Pos.: ☐ _____ mm			

NOTE: Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above.

Examinations and/or Inspections

Essential Findings Deviating from Normal:

Exam Date: / /

SECTION III - IMMUNIZATIONS

Statements such as "UP TO DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.*

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (Hep B)	1	3
	2	
DTaP/DTP/DT/Td	1	4
	2	5
	3	6
Tdap	1	
Haemophilus Influenzae type b (HIB)	1	3
	2	4
Polio - IPV / OPV	1	3
	2	4
Pneumococcal Conjugate (PCV7/PCV13)	1	3
	2	4
Rotavirus (RV1/RV5)	1	3
	2	
Measles,Mumps, Rubella (MMR)	1	2
Varicella (Chickenpox)	1	2

History of Cickenpox Disease? ☐ Yes ☐ No If yes, date:

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis A (Hep A)	1	2
Influenza TIV/LAIV	1	3
	2	4
Meningococcal MCV4 / MPSV4	1	2
Human Papillomavirus (HVP4/HPV2)	1	2
	2	3
	Type of Vaccine(s)	Date of Vaccine(s)
OTHER Vaccines Specify Date & Type	1	
	2	
	3	

Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable

*NOTE: According to Public Act 368 of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious and other objections, provided that the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your child's school or local health department.

Parent/Guardian refused immunizations: ☐

I certify that the immunization dates are true to the best of my knowledge

_____ _____ ___/___/___

Health Professional's Signature Title Date

SECTION IV - RECOMMENDATIONS

(Required for Child Care and Head Start/Early Head Start)

No	Yes	
☐	☐	Is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain:
☐	☐	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): ☐ Classroom ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ Other

Other Recommendations

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined _____'s teeth. As a result of this examination, my recommendation for treatment is: _____

child's name

_____ ___/___/___

Dentist's Signature Date

PHYSICIAN'S SIGNATURE

_____ ___/___/___ _____ _____

Examiner's Signature Date ***Examiner's Name (Print or Type)*** Degree or License

_____ _____ MI _____ (___) _____

Number & Street City ZIP Code Telephone

Information required for:

Early On - Hearing and Vision Status; Diagnosis; Health Status

Child Care Licensing - Physical Exam, Restrictions, Immunizations

Head Start/Early Head Start - Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the schedule of well-child care required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia and regular intervals based on age.

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Developed in Cooperation with the Departments of Human Services, Education, Community Health, Michigan American Association of Pediatrics, Early Childhood Investment Corporation, Child Care Licensing, Head Start, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons.

United Methodist Community House

INFANT / TODDLER
"ALL ABOUT ME" FORM

Child's Name: _____Date of Birth: _____/_____/_____

What would you like us to call your child?_____

DEVELOPMENTAL HISTORY

Age child began sitting: crawling_____ walking_____ talking _____

Does child: _____pull up _____crawl _____walk with support

Times child is fussy: _____

How do you handle these fussy times?_____

FAMILY INFORMATION

With whom does child reside?	
Who else lives in the home (siblings, extended family, pets)?	
What does child call family members?	
What is your current support system? (family, friends, neighbors, church, services, etc)	
Are there any needs your family is currently experiencing? (housing, transportation, parent support, financial, food, other)	
Are you currently involved with any services? (Maternal Infant Health, Arbor Circle, WIC, United Way, etc.)	
Language spoken at home	
Are books read in languages other than English?	
Are there words in your home language that we should know?	
Please tell us about any cultural family customs, rituals or traditions that will help us make your child's experience more meaningful	

HEALTH/ DEVELOPMENT

Serious illnesses or hospitalizations (describe)	
Any history of colic?	
Special physical conditions, disabilities, or allergies (describe)?	
Is your child presently or ever been diagnosed with a special need?	
If so, is he/she receiving any special services?	
Regular medications?	
Do you have any concerns about your child's development?	

EATING HABITS

Special characteristics or difficulties?	
Special diet:	
Formula: Breast Milk: How often	
Any food allergies?	
Have solid foods been introduced?	
If yes, please identify	
Favorite foods	
Foods refused	
Child eats: (on lap, in high chair, other)	
Child eats with (spoon, fork, hands, other)	

TOILETING/DIAPERING HABITS

Is there frequent diaper rash?				
Do you use:	Cream	Powder	Lotion	Other:
Are bowel movements regular/how often:	/			
Any problems with diarrhea or constipation:				
Is your child toilet trained:				
If yes, when did you begin?				
Any issues with urination or bowels:				
What is used at home:	Potty-chair	Special Seat	Regular Seat	
Word used for urination and bowel movement:				
Does your child have accidents:				

SLEEPING HABITS

Does child sleep in:	Crib	Bed	With Parents
Does child sleep in: ____ crib ____ bed ____ with parents			
Does child sleep on: (At center we must use "Back to sleep in accordance with our licensing policies)	Back *	Side	Stomach
Routine nap times:	: AM/PM		
	: AM/PM		
	: AM/PM		
Additional napping information?			
What does child take to bed?			
Mood on awakening:			
What time does child go to bed at night:	: PM		
What time does child awake in morning:	: AM		
Are there any sleep/wake time rituals?			

SOCIAL RELATIONSHIPS

Has child had any experience playing with children?	
If so, please describe.	
Is child: (Friendly, Aggressive, Shy, Withdrawn)	
Reaction to strangers?	
Have you had any previous child care experience?	
Did it meet your expectation, explain?	
Prefers to play: (alone, in small groups)	
Favorite toys and activities:	
Is child frightened by: (Animals, rough children, loud noises, dark)	
Other fears, please explain:	
How do you comfort your child when they are emotionally upset?	
How does your child prefer to be held?	

DAILY SCHEDULE

Please describe by approximate time your child's current daily activities:

Time		Activity (e.g., awakening, eating, time out of crib, napping, toilet habits, fussy time, bedtime)
:	AM PM	
:	AM PM	
:	AM PM	
:	AM PM	
:	AM PM	
:	AM PM	
:	AM PM	
:	AM PM	
:	AM PM	
:	AM PM	
:	AM PM	
:	AM PM	
:	AM PM	

PARENTING PHILOSOPHY

Do you have ideas about parenting that would help us to better care for your child as an individual?

What do you, as a family, hope to get out of this child care experience?

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

CHILD INFORMATION RECORD

State of Michigan - Department of Licensing and Regulatory Affairs - Child Care Licensing Bureau

Instructions: Unless otherwise indicated, all requested information must be provided. If the information is not known or does not apply, "unknown" or "none" is the required response. A blank field, a line through a field or "N/A" are not acceptable responses.

For Provider Use Only:	Date of Admission	Date of Discharge

Name of Child (Last, First, Middle Initial)				Child's Date of Birth
Address (Number and Street, Building/Apartment Number)		City	State	Zip Code
Parent/Legal Guardian's Name	Primary Phone ( )	Parent/Legal Guardian's Name (Optional)		Primary Phone ( )
Home Address (if not child's address)	2nd Phone (if applicable) ( )	Home Address (if not child's address)		2nd Phone (if applicable) ( )
City / State / Zip Code		City	State	Zip Code
Email Address (optional)		Email Address (optional)		
Employer Name	Work Phone ( )	Employer Name		Work Phone ( )
Name of Child's Physician or Health Clinic		Physician's or Health Clinic's Phone Number ( )		
Hospital Preferred for Emergency Treatment (optional)				
Allergies, Special Needs and/or Special Instructions? Yes ☐ No ☐ If yes, explain: (Attach additional sheets, if necessary.)				

CCL-3731 (Rev. 3/17/2022) Previous editions 7-18 & 4-21 may be used

See Reverse Side

Emergency Contact & Release of Child: List all individuals, including parents/legal guardians, in order of preference, to be contacted in an emergency. If possible, include at least one person other than the parents/legal guardians to be contacted in an emergency and to whom the child can be released. The second phone number column can be left blank. (If more individuals, attach additional sheets.)

1.	( )	( )
2.	( )	( )
3.	( )	( )

Release of Child Only: List all individuals, other than the parents/legal guardians, to whom the child may be released. (If more individuals, attach additional sheets.)

1.	**( )**	**2.**	**( )**
3.	**( )**	**4.**	**( )**

Parent/Legal Guardian Initials:

_____I give permission to _____, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical treatment for the above named minor child while in care.

I certify that I accurately completed this form and if anything changes, I will notify the provider by updating this form.

Signature of Parent or Guardian Date Signed

Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials

LARA is an equal opportunity employer/program.

AUTHORITY: 1973 PA 116
COMPLETION: Required
PENALTY: Rule Violation Citation.

CCL-3731 (Rev. 3/17/2022) Previous editions 7-18 & 4-21 may be used

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Field Trip Permission Form

Child Development Center (CDC)

Please complete the information below, allowing your child to travel off UMCH grounds for daily walks to various locations within walking distance from UMCH.

Statement of Consent
(Please print your responses.)

Name of Child: _____

Name of Parent/Guardian: _____

Address: _____
Street *Apt. #* *City* *Zip Code*

Telephone Number(s): H ( ) _____ W ( ) _____

C ( ) _____

Name of Emergency Contact: * _____

The emergency contact should be the same as is listed on the information card for the child.

Emergency Contact Telephone: ( ) _____

Release of Liability

As a parent or legal guardian, I acknowledge my responsibility for legal liability imposed on me as a result of any personal action taken by my child(ren). I also, for myself and my child(ren), release the United Methodist Community House from any liability for any accident, injury or property damage that may occur during a walking trip, that arises from any cause other than the sole negligence of the United Methodist Community House.

I hereby consent to the participation of my child(ren), named herein, in United Methodist Community House-sponsored walking trips that may occur during regular programming. I understand that these events will take place away from the UMCH grounds and that my child(ren) will be under the supervision of designated UMCH employees.

I understand that a reasonable effort will be made to reach me if it becomes necessary to arrange emergency medical care for my child(ren) due to accident or illness. I further agree that if I am not available to give me permission and direction in rendering emergency medical treatment, such care may be arranged without further consent. I personally assume responsibility for any costs for such treatment not covered by insurance.

I acknowledge and consent to the conditions stated above.

Name of Parent/Guardian: _____
Please Print

Signature of Parent/Guardian: _____

Date Signed: _____/_____/_____

United Methodist
Community House

Infant Formula/Food Permission Form
Child Development Center (CDC)

The Child Development Center of the United Methodist Community House (UMCH) participates in the Child and Adult Care Food Program (CACFP). UMCH is required to provide the same meals and snacks to all children, including age- appropriate foods for infants, unless otherwise provided by the parent/guardian.

R 400.8330 Food service and nutrition generally. Rule 330. Entries 1 – 5

(1) Snacks and meals shall be provided by the center, except when one (1) of the following circumstances occurs:
   a. A majority of the children are in attendance less than .5 hours.
   b. Food is provided by a parent.
(2) A written agreement shall be kept on file at the center if the parent has agreed to provide formula, milk, or food. The center shall provide an adequate amount of formula, milk, or food if the parent does not.
(3) Beverages and food shall be appropriate for the child's individual nutritional requirements, developmental stages, and special dietary needs, including cultural preferences.
(4) Solid foods shall be introduced to an infant according to the parent's or licensed health care provider's instructions.
(5) Infants shall only be served formula to drink unless written authorization is provided by the child's licensed healthcare provider.

Additionally Entries 9 – 12

(9) A center shall not deprive a child of a snack or meal if the child is in attendance at the time when the snack or meal is served.
(10) Menus shall be planned in advance, shall be dated, and shall be posted in a place visible to parents. Food substitutions shall be noted on the menus the day the substitution occurs.
(11) A center shall not serve infants and toddlers or allow them to eat foods that may easily cause choking including, but not limited to, popcorn, seeds, nuts, hard candy and uncut round foods such as whole grapes and hot dogs.
(12) Cereal shall not be added to a bottle or beverage container without written parental permission.

Name of Child: _____ Date of Birth: _____/_____/_____

By signing below, I elect to provide all infant formula and any age-appropriate infant foods for my child. I understand that if adequate formula/food are not provided, I may be subject to one or all of the following:

- The Center may call me to bring formula and/or food
- If the Center has made server attempts to connect with me for food and they are unsuccessful; UMCH is obligated to feed the child and will feed them iron-fortified infant formula; I understand I will be responsible for associated charges.

Signature of Parent/Guardian: _____ Date: _____/_____/_____

By signing below, I am stating that my child is able to consume solid, age-appropriate, infant foods provided by me or the center:

- If I choose to provide the solid age-appropriate infant foods and there is not enough provided for my child, UMCH will attempt to contact me. If the Center has made several attempts to connect with me for food and they are unsuccessful; UMCH is obligated to feed the child and will feed them solid age-appropriate infant foods; I understand I will be responsible for associated charges.

Signature of Parent/Guardian: _____ Date: _____/_____/_____

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Special Health Needs Form

Child Development Center (CDC)

Name of Child: _____ Date: _____

Please list the individual(s) authorized to have access to health information regarding the child listed above. (You may elect to refer the CDC to your child's information card, which provides emergency contacts for your child, individuals to whom your child may be released, and who may have access to personal health information.)

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

Important Health Information

Does your child have any health issues about which we should know? ☐ Yes ☐ No

If yes, what are their health issues? (Asthma, Nutritional Needs, Allergies, Hearing or Vision Impairment, Etc.)

_____

_____

What special instructions must be followed regarding your child's health issue(s)? (Please provide detailed information.)

_____

_____

If your child requires medication to be administered at UMCH, you must complete a Medication Form that provides specific instruction for the teacher(s). If you bring your child into care with medication, please give the medication to your child's teacher and complete a Medication Form. All medications are locked in a secure cabinet while at UMCH; consequently, you may need to remind the teacher(s) to return the medication to you when you pick your child up at the end of the day.

If your child may not have or be near any menu item due to allergies or special nutritional needs, or if your child requires specially prepared foods, you must provide an Individualized Health Care Plan from your child's health care provider. (This document is typically prepared in consultation with family members and specialists, if any, involved in the care of the child.)

The following individuals are permitted access to your child's personal health information as necessary at UMCH: Your child's teacher(s); the manager of the CDC; the director of programs; the manager of human resources, and the chief executive officer.

By signing below, you confirm that the information provided herein is accurate to the best of your knowledge.

Signature of Parent/Guardian: _____ Date: _____

United Methodist Community House

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Infant Safe Sleep Policy

Child Development Center (CDC)

Objective: To provide a safe sleep environment for all infants (defined as children from birth to 12 months of age) and to ensure that parents or the individual responsible for the child's care are provided with consistent information regarding safe infant sleep procedures and expectations.

Policy: All teachers and other caregivers (for example, volunteers) of the CDC will adhere to the following Infant Safe Sleep guidelines.

1. Infants shall be placed on their backs for resting and sleeping, even if/when they can roll over by themselves.
2. Infants shall rest or sleep alone, in an approved crib with a firm mattress and a tightly fitting bottom sheet.
3. Infants' faces shall remain uncovered during sleep to ensure ease of breathing.
4. Infants shall sleep in a smoke-free environment.
5. Infants shall be dressed in as much or as little clothing as necessary to ensure that they do not become chilled or over-heated. Sleep sacks may be used for this purpose.
6. Infants shall have nothing placed in the crib, i.e. no blankets, pillows, comforters, stuff animals or other soft toys, etc.
7. If an infant is unable to be placed on their back for resting and sleeping due to a physical disability or illness, the parent/guardian shall provide written instructions (signed and dated by the child's physician) that detail an alternative safe sleep position and/or other special sleeping arrangements for the infant. All caregivers shall adhere to the physician's written instruction with regard to resting and sleeping requirements for the infant.
8. Infant caregivers shall provide daily opportunity for supervised "tummy time" for awake infants.

As the parent/guardian of an infant enrolled in the Child Development Center of the United Methodist Community House, I have read, understand and agree with the CDC's safe sleep policy.

Signature of Parent/Guardian: _____ Date: _____

United Methodist
Community House

Increasing everyone's ability to succeed in a diverse community.

TODDLER BITING POLICY

Child Development Center (CDC)

Biting is a developmental stage that many children naturally go through between nine (9) months and three years of age. The safety of children is our primary concern. However, we understand most biting is a form of communication. Toddlers have emerging verbal skills are often impulsive without a lot of self-control. Sometimes biting happens for no known reason. The teachers will encourage children "to use their words" when upset. Also, they will help children with the words they may need to describe their frustrations. Most importantly the staff will strive to shadow a child as closely as they can when biting is a concern.

If a child is bitten, the child who was bitten will be immediately cared for and shown concern. The child who did the biting will be acknowledged with a "No-we don't bite." The child who is bitten will continue to be comforted. The child who was the biter will be removed from the situation and be given something to satisfy them such as a teether or other item. The teachers will stay calm. The bite will be assessed and cleansed with soap and water. The families of both children will be notified of the biting incident. The incident report will be completed. Confidentiality of all children involved will be maintained.

Staff in the classroom will work closely to develop a plan for the child who is biting. This is developed with the assistance of the family. This often will include tracking the biting in a journal with details such as day, time of day, whom they are playing with, what area they are playing in, etc. This information will assist the staff in developing strategies to address the issue.

ACKNOWLEDGMENT

By signing below, I understand that failure to abide by the policies and procedures outlined by the Child Development Center may result in the termination of my child's enrollment in its services. Failure to abide with policy or procedure may include but is not limited to: ignoring state licensing rules and regulations; not keeping the financial account current; aggressive, loud and/or argumentative interactions with UMCH employees; sexual harassment; hostile telephone calls, voice mail messages or e-mail communications. I understand that UMCH reserves the right to maintain a harmonious and safe environment for the children in its care. I understand the goal is to facilitate collaboration between home and school in ways that enhance my child's development.

Signature of Parent: _____ Date: _____

Family Promise of Grand Rapids/United Methodist Community House

RELEASE OF INFORMATION

I, _____ grant permission for the release of information to and from Family Promise of Grand Rapids and United Methodist Community House to the following agencies as it relates to family engagement services, and I understand that this information will be confidential and that I can withdraw this release at any time by contacting the UMCH Family Engagement Specialist. This release of information will stay active while my child(ren) is enrolled at United Methodist Community House.

Agency/Program Description:

Arbor Circle	Lean on Me Outreach Center
Baxter Community Center	Mel Trotter Ministries
Bethany Christian Services	Network 180
Catholic Charities of West Michigan	The Urban League of West Michigan
Food Pantry Resources	The Salvation Army-Housing Assessment Program
Community Rebuilders	United Way-211
D.A. Blodgett-St. John's	Signify-GRACE Network
Family Futures	Department of Health and Human Services (DHHS)
Family Outreach Center	Great Start to Quality
Habitat for Humanity	Home Repair Services
Healthy Families	Home Visiting Programs
Maternal Infant Health	Women, Infants, and Children (WIC)
Strong Beginnings	Baby Scholars
Moms Bloom	Safe Families for Children
Early Childhood Services	Basic Needs Services
Easterseals	Help Me Grow
Alpha Women's Center	Kent Intermediate School District (KISD)

Please do not release any information to the following individuals or agencies:

_____

_____

_____

_____

Parent/Guardian Signature **Date**

_____

Parent/Guardian Signature **Date**

_____

Family Engagement Specialist Signature **Date**

United Methodist
Community House

IPM Notice to Parents

Dear Parent or Guardian:

The United Methodist Community House school/daycare utilizes an integrated Pest Management (IPM) approach to control pests. IPM is a pest management system that utilizes all techniques in a total pest management system with the intent of preventing pests from reaching unacceptable levels· or to reduce an existing population to an acceptable level Pest management techniques emphasize pest exclusion and biological controls, However as with most pest control programs, pesticides are occasionally applied.

You have the right to be informed prior to any application of an insecticide, fungicide or herbicide made to the school grounds or buildings during the school year. In certain emergencies, such as an infestation of stinging insects, pesticides may be applied without prior notice to prevent injury to students but you will be notified following any application. Parents will be notified by a letter sent home, and with an email message through Procare.

Facility Name: United Methodist Community House

Facility Address: 904Sheldon Ave SE, Grand Rapids, Ml 49507

Contact Person: Dwayne Moore or Marcy Steenstra

Phone Number: 616-452-3226

United Methodist
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Increasing everyone's ability to succeed in a diverse community.

Parent Notification RE: Licensing Notebook

Child Care Organizations Act, 1973, Public Act 116
Michigan Department of Human Services

Child Development Center (CDC)
United Methodist Community House

All child care centers must maintain a licensing notebook that includes all licensing inspection reports, special investigation reports, and all related corrective action plans (CAP). The notebook must include all reports issued and CAPs developed, until such time as the license is closed. The UMCH licensing notebook is available for review and accessible to parents. This notebook is located on the parent information stand, outside the Director's office.

Please be informed:

- The licensing notebook contains all the licensing inspection and special investigation reports and related corrective action plan for the last 5 years.
- The licensing notebook is available to parents during regular business hours.
- Licensing inspection reports, special investigation reports, and corrective action plans from at least the past 3 years are available on the department's child care licensing website at www.michigan.gov/michildcare.

By signing below, I acknowledge that I have read the statement issued above by the Child Development Center of the United Methodist Community House.

Signature of Parent/Guardian: _____ Date: _____

(Printed) Name of Parent/Guardian: _____

Name(s) of Child(ren): _____

_____

_____

United Methodist
Community House

Child Development Center Parent Handbook

Child Development Center Parent Acknowledgement Form

The Child Development Center Parent Handbook describes important information about the Child Development Center and I understand that I should consult the CDC Director regarding any questions not answered in the Handbook.

I understand and acknowledge that the information, policies and benefits described in this Parent Handbook are necessarily subject to change. I acknowledge that revisions to the Handbook may occur, that all such changes will be communicated through official notices, and that revised information may supersede, modify or eliminate existing policies.

This Handbook is provided as a guideline for policies and benefits. It does not constitute a contract of employment between UMCH and Clients.

I have received the Handbook and I understand that it is my responsibility to read and comply with the policies contained in this Handbook and any revisions made to it.

_____ _____

Printed or Typed Name of Parent/Guardian Name of Child

_____ _____

Signature of Parent/Guardian Date

United Methodist
Community House

Dear Participant/Parent-Guardian:

This letter is intended for adults/parents or parents/guardians of participants enrolled in a day care center. UMCH offers healthy meals to all enrolled participants 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 participants enrolled in care. Please help us comply with the requirements of the CACFP by completing the attached Household Income Eligibility Statement (HIES). In addition, by filling out this form, we will be able to determine eligibility for free or reduced price meals. For compliance, every family must have one on file, even if they are not eligible.

1. Do I need to fill out a HIES for each participant enrolled in care? You may complete and submit one CACFP Household Income Eligibility Statement for all participants enrolled in day care in your household only if those in day 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: UMCH | 904 Sheldon Ave. SE | Grand Rapids, MI 49507

2. Which adult and child care institutions can receive free meal reimbursement without providing household income information? Adults receiving Medicaid, Supplemental Security Income (SSI), Food Assistance Program (FAP) Family Independence Program (FIP), or Food Distribution Program on Indian Reservations (FDPIR) are eligible for free meals. Children in households receiving FAP, FIP, or FDPIR can get free meals. Foster children and children enrolled in Head Start Programs are also eligible for free meals.

3. Who can get reduced price meals? You may get low cost meals if your household's income is within the reduced-price limits on the federal income eligibility guidelines, **effective July 1, 2020 until June 30, 2021**, shown below:

Family Size	Yearly Income	Monthly Income	Weekly Income
1	$23,107	$1,926	$445
2	$31,284	$2,607	$602
3	$39,461	$3,289	$759
4	$47,638	$3,970	$917
For each additional family member add:	$8,177	$682	$158

Refer to the Instructions for Participants/Parents/Guardians Household Income Eligibility Statement on how to complete the HIES. Find the category that most closely defines your household and follow the directions for completing each part of the HIES. If your household income is greater than the levels shown on the above CACFP income guidelines, it is not necessary for you to complete the HIES form.

Families with Children:
Your family may be eligible to receive health insurance, called MIChild, through the State of Michigan. MIChild is a health insurance program for uninsured children of Michigan's working families. To determine if your family is eligible, call 1-888-988-6300 for an application or access an online application at the MI Child website (www.michigan.gov/michild). You can also access the MIChild brochure that briefly explains the insurance program.

Your family may be eligible to receive Women, Infants & Children (WIC), a health and nutrition program, that has demonstrated a positive effect on pregnancy outcomes, child growth and development. To determine eligibility, call 1-800-26-BIRTH or access online information at Women, Infants, & Children (WIC) website (http://www.michigan.gov/wic) to learn about WIC and locate a local WIC agency.

4. May I fill out a form if someone in my household is not a U.S. citizen? Yes. Participants and family members do not have to be U.S. citizens to qualify for meal benefits offered at the center.

5. Who should I include as members of my household? You must include all people in your household (such as grandparents, other relatives, or friends who live with you). 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 and the frequency the income is received. If recent income does not accurately reflect your circumstances, you may provide a projection of your 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 federal income eligibility guidelines listed above, the family day care home will receive a higher level of reimbursement. Once properly approved for the higher reimbursement rate, whether through income or by providing a current FAP, FIP, FDPIR case number, or listing the name of other categorically eligible programs, you will remain eligible for those benefits for 12 months. You should, however, notify us if you or someone in your household becomes unemployed and the loss of income unemployment 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 receive. For example, if you normally receive $1,000 every two weeks, but you missed some work in the last two weeks and only received $900, put down that you receive $1,000 per every two weeks. If you normally receive overtime, include it, but not if you only receive 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 HIES, but are not required to include payments received for the foster child as income.

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, the U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you have other questions or need help, call [phone number].

Sincerely,

Marcy Steenstra

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) (http://www.ascr.usda.gov/complaint_filing_cust.html) online, 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.

Return this completed form to: UMCH | 904 Sheldon Ave. SE | Grand Rapids, MI 49507 | 616-452-3226

Participant Enrollment Form

Instructions:

1. List full name of participant enrolled in care
2. Circle the typical days each participant is in care
3. List times each participant is in care
4. Circle the meals and snacks each participant typically receives while in care
5. Select the ethnicity of each participant using the following codes: H = Hispanic or Latino, N = Not Hispanic or Latino*
6. Select one or more racial designations of each participant using the following codes: A/I = American Indian or Alaskan Native, A = Asian, B = Black or African American, H/PI = Native Hawaiian or Pacific Islander, W = White*
7. Sign and date the form and return to your care center

Participant's First and Last Name	Typical Days in Care (circle all that apply)	List Times in Care	Meals/Snacks Received (circle all that apply)	Ethnicity	Race
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		

* This information is voluntary. This will assist us in assuring the Child and Adult Care Food Program is administered in a nondiscriminatory manner.

_____ Adult/Parent/Guardian's Address

_____ Adult/Parent/Guardian's Phone Number

_____ Signature of Adult/Parent/Guardian

_____ Date Signed

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MICHIGAN Department of Education

Michigan Department of Education
Child and Adult Care Food Program

Where Healthy Eating Becomes a Habit

Program Information Sheet

This care center is a participant in the Child and Adult Care Food Program (CACFP), a United States Department of Agriculture (USDA) program. The CACFP provides cash reimbursement to child and adult day care centers for nutritious meals and helps children and adults develop and maintain healthy eating habits. The CACFP is administered by the Michigan Department of Education (MDE).

Through the Child and Adult Care Food Program you can be assured each participant is getting balanced, nutritious meals and developing/maintaining healthy lifelong eating habits. Proper nutrition during throughout life ensures fewer educational and physical problems later in life.

As a participant in the CACFP, your care center receives reimbursement for serving nutritious meals and snacks. Meals and snacks must meet the USDA meal pattern requirements listed below (Child Meal Pattern).*

Breakfast	**Lunch and Supper**	**Snack (serve 2 different food items from the 5 food component groups below)**
Milk	Milk	Milk
Fruit, Vegetable, or a combination of both	Meat or Meat Alternate Vegetable Fruit (or second Vegetable)	Meat or Meat Alternate Vegetable Fruit
Grain	Grain	Grain

**Children less than one year old and Adults Day Services:* Foods in the infant and adult meal pattern vary. Please request the applicable infant or adult meal pattern requirements from our center.

MDE is required to verify the enrollment, attendance and meals/snacks typically consumed by children while they are in care. MDE staff may contact you regarding your child's participation in our day care center.

If you have any questions about the Child and Adult Care Food Program, please contact:

United Methodist Community House Center
904 Sheldon Ave. SE
Grand Rapids, MI 49507
616-452-3226

or

Child and Adult Care Food Program
Michigan Department of Education
P.O. Box 30008
Lansing, Michigan 48909
517-241-5353

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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.

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MICHIGAN Department of Education

Rev. 6/2019

Instructions for Parents/Participants/Guardians
Household Income Eligibility Statement - Child Care Institutions

If you are applying for foster child(ren) only, follow these instructions:
Part 1: Do not complete.
Part 2: List name, age, and birth date of foster child(ren); check the box for foster child.
Part 3: Sign and date the form. The last four digits of a social security number are not necessary.

If your household receives Food Assistance Program (FAP), Family Independence Program (FIP), or Food Distribution Program on Indian Reservations (FDPIR) benefits, follow these instructions:
Part 1: List the name and case number for any household member (including adults) receiving FAP, FIP, or FDPIR.
Part 2: List the name, age, and birth date for all children enrolled in day care.
Part 3: Sign and date the form. A Social Security Number is not necessary.
Note: Benefits received under WIC, Medicaid, or Department of Health and Human Services (DHHS) Child Care Assistance Program (where DHHS pays a portion of your child care expense) does not automatically qualify for Category A (free) meals.

All other households, including households where some of the children are foster children, follow these instructions (not required if household is over the income limits and don't have any foster children):
Part 1: Do not complete.
Part 2: List the names and ages of everyone (related or not related) living in your household, including you, other adults and children (If you need more space, use a separate sheet of paper.)

Place a ✓ in the column for all children enrolled in child care

List household members' ages and dates of birth

Place a ✓ in the next column if children in the household are foster children

If no case number is indicated in Part 1, list (by person) the amount and source of income received last month. List monthly earnings **before** deductions, monthly welfare, child support or alimony or any other income including retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits, Worker's Compensation, unemployment, strike benefits, regular contributions of people who do not live in your household or any other income

Place a ✓ in the box for those listed who do not have income

If you are in the Military Housing Privatization Initiative or receive Combat Pay, do not include the housing allowance as income

Foster child payments received by the family from the placement agency are not considered income and do not have to be reported. The presence of a foster child in a family does not make all children in the household automatically eligible for free meals

If you are a farmer or self-employed, monthly income is gross farm or business income received in the month prior to application minus farm or business expenses. Gross wages from other jobs or income from other sources must also be listed as income. A loss from self-employment must be listed as zero income and cannot reduce other income

Part 3: Sign and date the form and list the last four digits of your Social Security Number or check the box indicating "I do not have a Social Security Number."

Help With Income To determine annualized income:
If paid every week, multiply the total gross income by 52.
If paid every two weeks, multiply the total gross income by 26.
If paid once a month, use the total gross monthly income.
If paid twice a month, multiply the total gross income by 24.
If paid once a year, use the total gross yearly income.

Return the completed application to the child care center.

Non-Discrimination Statement

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Return this completed form to: ***UMCH | 904 Sheldon Ave. SE | Grand Rapids, MI 49507***

Household Income Eligibility Statement – Child Care Institutions

Part 1 – Households Receiving Food Assistance Program (FAP), Family Independence Program (FIP), or Food Distribution Program on Indian Reservations (FDPIR)

If any member of your household receives FAP, FIP, or FDPIR, provide the name and case number for the person who receives the benefits.

Name:_____ **Case Number:** ___ ___ ___ ___ ___ ___ ___ ___ ___

Part 2 – Household Information

First and Last Names of All Household Members, Related and Unrelated	Enrolled for Child Care (x)	Age	Birth Date	Foster Child (x)	Amount of Earnings from Work (before deductions)	How Often? (x) Annually	Monthly	2xMonth	BIWeekly	Weekly	Amount of Welfare, Child Support, or Alimony	How Often? (x) Annually	Monthly	2xMonth	BIWeekly	Weekly	Amount of All Other Income (Indicate source and amount)	How Often? (x) Annually	Monthly	2xMonth	BIWeekly	Weekly	Mark if No Income (x)

Part 3 – All Households: Signature and Last Four (4) Digits of Adult Social Security Number (Adult household member MUST sign and date)

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 receive 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.

Signature: _____ Print Name:_____ Date: _____

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

For Institution Use Only:

For Institution Use Only		
Total Household Members:	Total Income: $ ___ Annually ___ Monthly ___ 2x Month ___ Bi-Weekly ___ Weekly	APPROVED CATEGORY Categorical Eligibility (A/Free): Foster FIP FAP FDPIR Other Household Children: A (Free) B (Reduced) C (Paid)
Institution Official Signature: _____ Approval Date: _____		

This form is valid for 12 months from the date of institution signature. Approval date and institution signature are required.

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 Food Assistance Program (FAP), Family Independence Program (FIP), 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.

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MICHIGAN Department of Education
Rev 6/2019

United Methodist Community House
Increasing everyone's ability to succeed in a diverse community

Tuition Agreement
Child Development Center (CDC)

Name of Child: _____ Date of Birth: ____/____/____

Please Select Care Schedule: ☐ Room 101 ☐ Room 102 ☐ Room 201 ☐ Room 202

☐ Room 301 ☐ Room 302 ☐ Room 303 ☐ Room 304

Hours of Operation: Monday through Friday, 7:00 AM to 5:30 PM

Please indicate below when services are needed. Please circle AM or PM for both the Time In and Time Out Columns.

Day	Time In	Time Out	Total Hours
Monday	_____ AM PM	_____ AM PM	
Tuesday	_____ AM PM	_____ AM PM	
Wednesday	_____ AM PM	_____ AM PM	
Thursday	_____ AM PM	_____ AM PM	
Friday	_____ AM PM	_____ AM PM	

PLEASE NOTE:

- This Tuition Agreement is a written contract.
- If your child is at the CDC for hours beyond those outlined in this Agreement, you will be billed for those additional hours, as well.
- Payments are due one week in advance.
- We bill for all days your child is scheduled to attend, even if your child does not attend, including sick days.
- We do charge for holidays if they fall in a regular schedule week. (If a decision to the contrary is made by the chief executive officer, notices will be forwarded to CDC parents and will be posted throughout the agency.
- If your child has planned time off, you must submit a Vacation Notice to the manager of the CDC. This notice must state which day(s) your child will be out and the first day they will be back at UMCH. Please submit this vacation notice in writing at least two weeks prior to the scheduled time off. The manager will inform the teachers and the finance department if your child has a planned absence.
- It is your responsibility to update your tuition agreement if needed.
- Tuition rates are billed weekly, according to the number of hours for which your child is enrolled. You will be billed in one of the following ranges: 21-44 Hours / 45 + Hours
- It is your responsibility to submit a Withdrawal Notice two weeks in advance if you plan to end your child's care at the CDC.

Number of care hours requested for your child, per week: _____

You will be billed an amount of $ _____ for these scheduled hours, on a weekly basis.

Your child's first day of care will be: _____/_____/_____

PLEASE NOTE: Your initial payment is due 1 week before the first scheduled day of care.

By signing below, I understand and agree that the Tuition Agreement is an ongoing contract, unless otherwise noted herein in writing. I further understand and agree that I will be charged and billed each week for tuition amounts outlined herein, until a formal Withdrawal Notice has been submitted to the manager of the CDC.

Signature of Parent/Guardian: _____ Date: _____

Signature of Program Manager: _____ Date: _____

United Methodist Community House

Child Development Center

Tuition and Payment Policies

"Did You Know?"

United Methodist Community House (UMCH) provides the following understanding of our tuition and payment policies, to ensure families understand all the financial implications of enrollment.

- UMCH bills 50 weeks per year. Families are obligated to pay for 48 weeks, while enrolled at United Methodist Community House (UMCH). These four (4) weeks are comprised of our annual spring break, Agency year-end closure, and parent's two (2) weeks vacation. I understand that I will be charged for a full week of care, regardless of days used. This includes Agency closures that happen periodically, both planned and unplanned.
  _____ **Initial**

- UMCH allows families two (2) weeks of vacation time. All vacation requests must be submitted in writing to the Center Director two (2) weeks prior to the period of time the child will be on vacation. I understand that all vacation requests must be in increments of one (1) week, and all five (5) days occurring in the same week. I understand I will not be charged while on vacation. _____ **Initial**

- Tuition is paid weekly, in advance of services. I understand this means tuition must be paid the week prior, by Friday at 6:00 pm, for CDC services the following Monday. I understand payment is also due weekly. I understand that I have a grace period of 1 week to satisfy my account, should it become delinquent. I understand services will be placed on hold until payment is made in full. Once service is held for two weeks the child(ren) will be dis-enrolled. _____ **Initial**

- Service fees are generated, beginning at 11 minutes before scheduled drop off or after scheduled pickup time. The cost is $5 per minute. I understand that these fees will be applied to my weekly total due and I will be responsible to have them paid in full, before the next week of service. Late payment of these types of fees will be treated the same as late tuition. _____ **Initial**

- UMCH only accepts electronic payment for all services, through the Tuition Express platform. I understand it is my responsibility to set up MyProcare and manage my payments from there. _____ **Initial**

- Cancellation of enrollment must be made formally, in writing, two (2) weeks prior to the end date of service. This notice is to be given to the Center Director. UMCH charges two weeks, from the time notice is submitted. Timeframes are counted in weeks. I understand failure to provide sufficient notice of withdrawal may result in paying weekly program fees, even if my child is no longer attending. _____ **Initial**

- Withdrawal of my child does not relieve me of any unpaid balance on my account. I understand I am responsible for the full balance of the account. I understand UMCH may engage in collection services for unpaid debts.
  _____ **Initial**

- I understand that if my child is discharged from the CDC for reasons of non-payment for services or an excessive outstanding balance, re-enrollment of my child will not be permitted until my account reflects a zero ($0) balance. _____ **Initial**

I am a private pay client _____ **I receive subsidy to help cover the cost of care _____**

Please continue, if you receive subsidies of any kind.

The following must also be understood:

- If tuition is subsidized by another individual or organization, I understand that I am responsible for any amount of tuition not covered or otherwise denied for payment. I understand that I will be notified immediately of any denial or termination of payments by the individual or organization subsidizing my CDC fees. **_____ Initial**

- Your benefits start on date_____ and end on _____. You are responsible for contacting DHHS when any of your information that is required for DHHS benefit approval changes.

- Every DHHS fiscal year (Oct 1- Sept 31), you are allowed up to 360 absent hours. UMCH will bill for the days we are closed for teacher in-service trainings, holidays and any other unexpected closures. These closures will use at least 216 of your absent hours (for example- 27 days X your scheduled hours/day), leaving an estimated 144 hours for you to use.

- Although DHHS may inform you that you have a $0 contribution benefit, this only pertains to DHHS specific benefits, independent from UMCH payment rates. You still may have a co-pay with UMCH. Please make sure you are aware of this amount and make payments accordingly.

- DHHS approves individuals for an allotted amount of hours per week; therefore, if you do not use all of your allotted hours, DHHS will only pay for the hours your child was in care. You will then be responsible for paying your remaining contract hours out of pocket. For example, if one day you dropped your child off late and another day you picked up early, DHHS will only pay for the hours you child was actually in care, not for the hours they are approved to be in care.

    - You cannot use absent hours for partial days missed. This rule is also true for sick days, if you no longer have absent hours left to use.

- If your account becomes past due:
    - You will be informed by the following Monday via email and phone that your account is past due.
    - You will then be given 5 days to resolve the issue by:
        - Paying your balance
          OR
        - Coming up with a payment plan with the UMCH Accounts Assistant
    - If your account issue is not resolved within by the second following Monday of your account being past due, you will be denied entry until it is resolved.
      *Should your entry be denied, you will receive an email and phone call informing you of your account status.

Signature of Parent or Guardian: _____ Date: _____

Signature of UMCH Billing Specialist: _____ Date: _____

All Billing inquiries:

Gregory Booker	**Billing Specialist**	**gbooker@umchousegr.org**	**616.452.3226 Ext. 3001**

All General inquiries:

Marcy Steenstra	**Center Director**	**msteenstra@umchousegr.org**	**616.452.3226 Ext. 3007**

United Methodist
Community House

Increasing everyone's ability to succeed in a diverse community.

Parent Policy Agreement

Child Development Center (CDC)

As a parent of a participant in the United Methodist Community House (UMCH) Child Development Center (CDC), I affirm that I have met with the Center Director and reviewed the Parent Handbook. By signing below, I agree to and understand the following:

Your child's safety and the successful operation of the Center require parent cooperation with Center policies. Parental requirements are listed below:

1. Support and comply with all UMCH policies and procedures; read all Center information and newsletters provided; Check for special information posted on bulletin boards throughout the Centers.
2. Be financially responsible by paying in full current and late fees of my account; be familiar with UMCH billing policies and breaks. UMCH provides a one (1) week grace period: delinquency by one (1) week will result in notification that program dismissal is pending; delinquency by two (2) weeks will result in program dismissal.
3. Abide by the drop-off/Attendance policies:
    a. Parents will not drop-off children, during nap/quite time, between the hours of 11:30 am and 2:00 pm.
    b. Parents must walk their child into and out of the classroom during drop-off and pick-up times.
    c. Parents must use the biometric finger scanner to Sign-In/Out; if there is an issue, the Service Desk can assist with minor account access and troubleshooting.
    d. UMCH does not support care in excess of 10 hours per day; should this be requested, parents will participate in an approval process; approval will be on a case-by-case basis, with the child's best interest as the focal point.
4. Communicate special instructions, ideas or concerns that they might have with the child's teacher.
5. Provide the Center with diapers, formula, breast milk, food, special foods, changes of clothing or any other item necessary for the care of your child. You must provide these items within a reasonable timeframe if the Center calls informing you, your child is out of one of these essential items. **Failure to provide these items can result in a denial of services, until adequate supplies are received**.
6. Adhere to the Center's policy regarding children who are ill and comply with the 24-hour "symptom-free" policy.
7. Pick my child up promptly in the event of injury or illness while at the Center. **Failure to do so can result in suspension from the Center or dismissal.**
8. Keep telephone numbers, emergency contract information and other enrollment information for my child current.
9. Follow regulations regarding dispensing medication and complete all forms necessary to this end.
10. Keep my child's immunizations current and provide copies of immunization updates to the Center.
11. Attend and participate in all parent/teacher conferences or meetings requested by my child's teacher.
12. Cooperate with the teachers and follow-up on the medical, dental, or developmental needs and/or referrals for my child.
13. Be willing to learn and grow as a parent and increase my knowledge of child development.
14. Discuss my concerns and maintain open communication with the teacher and Center in order to avoid miscommunication and subsequent misunderstandings.
15. Exhibit and model respect for UMCH employees and other Center families.
16. Notify the Center if your child is going to be absent (if ill, by 10:00 am the day of), going on vacation (2 weeks in advance), etc.

17. Notify the Center Director of any change in scheduled arrival or departure times for the child. If this is a permanent change, complete a new Tuition Agreement form; Tuition Agreement forms require approval from the Center Director and must be submitted one (1) week in advance of requested change.
18. Provide appropriate apparel for outside activities and play (footwear, coats, mittens, hats, snow pants, swimsuits, etc).

Each parent of a child enrolled in the Center has rights, including:

1. Parents have the right to discuss any concern, complaint or problem with the Manager of the Child Development Center.
2. Parents have the right to comment on all program planning of the Center.
3. Parents have the right to view all records maintained on their child by the Center.
4. Parents have the right to view menus for meals and snacks.
5. Parents have the right to make special dietary request for their child for religious of health concerns.
6. Parents have the right to apply for membership to the UMCH Board of Directors as a neighborhood representative and/or service recipient.
7. Parents have the right to request referrals for services for their child.
8. Parents have the right to seek explanation concerning any discipline used with their child.
9. Parents have the right to waive any and all immunizations for their child, for religious or medical reasons. (Please note, however, that the approval process for this waiver is a lengthy one via the Kent County Health Department.)
10. Parents have the right to receive a yearly fee statement for income tax purposes.
11. Parents have the right to discuss your fee or invoices with the Accounting Specialist.

By signing below, I understand that failure to abide by the policies and procedures outlined by the Child Development Center may result in the termination of my child's enrollment in its services. Failure to abide with policy or procedure may include but is not limited to: ignoring state licensing rules and regulations; not keeping the financial account current; aggressive, loud and/or argumentative interactions with UMCH employees; sexual harassment; hostile telephone calls, voice mail messages or e-mail communications. I understand that UMCH reserves the right to maintain a harmonious and safe environment for the children in its care. I understand the goal is to facilitate collaboration between home and school in ways that enhance my child's development.

Signature of Parent: _____ Date: _____