

Parent Provider Contract

A. The following contract is between _____
and **Scribbles and Giggles Day Care Center, LLC.** located at **1880
Hamilton Rd.** for the children listed below:

Childs Name _____	Date of Birth _____
Childs Name _____	Date of Birth _____
Childs Name _____	Date of Birth _____
Childs Name _____	Date of Birth _____

B. Standard Rates and Payment Policies:

1. A deposit of \$150.00 per child is required.
2. The fee will be as follows:
30-39 hours - \$175 per week
40-49 hours - \$215 per week
50+ hours - \$230 per week
3. Days of hour and care provided will be 6:00am-10:00pm, **Mon-Fri,**
Saturday 6:00 am to 7:00 pm
4. Payment is to be given weekly or monthly prior to drop off.
5. The child care provider will provide **Breakfast, Lunch, PM snack,**
Dinner, and night snack.
6. The parent(s)/guardian(s) will provide the following: **Change of
clothes; infant formula or breastmilk; diapers and wipes.**

C. Rates for holidays, absences, vacations, overtime:

1. The provider will be notified by 7am if the child(ren) will be absent for
the day.
2. Policy for payment of absences is all scheduled days must be paid.
3. Fees and policies for providers vacation is none.
4. Fees and policies for parent/guardian's vacation **5 unpaid absent
days with prior notice.**
5. If the provider is unable to provide care because of illness or
emergency, tuition is due

6. If the parent(s)/guardian(s) drops off the child earlier or picks up later than the times specified above, the following overtime rate will be charged: \$1.00 per minute or portion thereof.

D. Damages

The policy on damage caused by the child(ren) while in the provider's care unless caused by negligence of the provider is reimbursement for any extensive damages.

E. Termination

This contract begins on the following date _____ and may be terminated by either parent/guardian or provider by giving 2 weeks' written notice. The provider may terminate the contract without notice if the parent(s)/guardian is over 2 weeks late notice with scheduled payments. Parents/guardians may terminate the contract without notice if the provider does not comply with MI child care regulations/laws. Changes to the contract, desired by either provider or parent/guardian, must be made in writing and acknowledged in writing by the other parties at least 2 weeks before the desired change takes effect. A new contract may be signed at the time to reflect the changes.

F. Signatures

By signing this contract, all the parties agree to all of the above terms and policies, including financial responsibility for child care provided. The provider is responsible for providing all parties a copy of the signed contract.

Providers Signature: *Jennifer L Wilson* Date: _____

Legal Guardian Signature: _____

Date: _____

Address of Legal Guardian: _____

Phone Number: _____

Scribbles and Giggles Day Care Center, LLC

I, _____ Parent or guardian of _____

Have read and understand that my payment is due prior to the care of my children. If my payment is not current my children will not be able to attend the center until the payment is current. This payment will include the current and past amount due. You will be turned away at the door if necessary. There are no exceptions to this rule.

Signature: _____

Printed Name: _____

Date: _____

MDHHS-3305, HEALTH APPRAISAL
 Michigan Department of Health and Human Services (MDHHS)
 (Revised 7-24)

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 1. Section 4 may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse, dentist, dental therapist, and dental hygienist.

(BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION).

SECTION 1 – PERSONAL

Child's Name (Last, First, Middle)	Date of Birth (mm/dd/yy)
Address (Number, Street, City, Zip Code)	Today's Date (mm/dd/yy)
Parent/Guardian (Last, First, Middle)	Home/Cell Phone Number
Address (Number, Street, City, Zip Code)	Work Phone Number

SECTION 2 – HEALTH HISTORY

Yes	No	Resolved	Is your child having any of the problems listed below?	Birth History
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Allergies or Reactions (for example, food, medication or other)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Anaphylaxis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Does your child take any medication(s) regularly?	If yes, list medications
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Hay Fever, Asthma, or Wheezing	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Eczema or Frequent Skin Rashes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Convulsions/Seizures	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Heart Trouble	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Frequent Colds, Sore Throats, Earaches (4 or more per year)	Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Trouble with Passing Urine or Bowel Movements	If yes, describe

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Shortness of Breath	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. Speech Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Menstrual Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. Dental Problems Date of Last Exam OR Date of Last Assessment	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Other (describe)	

Reason for Medication

Concussion History

Parent/Guardian Signature

Date

Was the health history reviewed by a health professional?

Examiner's Initials

Yes No

SECTION 3 - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Test and Measurements

Yes	No	Was child test for	Tests and results	Normal	Referred	Under Care
<input type="checkbox"/>	<input type="checkbox"/>	Vision	Visual Acuity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Date	Muscle Imbalance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hearing	<input type="checkbox"/> Audiometer (R= Right, L=Left)			
		Date	<input type="checkbox"/> OAE (R= Right, L=Left)			
			<input type="checkbox"/> Other (R= Right, L=Left)			
<input type="checkbox"/>	<input type="checkbox"/>	Urinalysis	Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Albumin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Microscopic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Blood Lead Level	Level ug/dl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Date				

Note: All children in Medicaid need to be tested at 1 and 2 years of age, or once between 3 and 6 years of age if not previously tested. All children, regardless of Medicaid status, should be tested at those same ages if they live in an area where lead risk is high.

<input type="checkbox"/>	<input type="checkbox"/>	Height & Weight	Height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hemoglobin/Hematocrit	→	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Blood Pressure	Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Complete pediatric tuberculosis risk assessment available at:
https://www.michigan.gov/documents/mdhhs/4_MI_Pediatric_TB_Risk_Assessment_661537_7.pdf **OR**
 feel free to use the attached QR code instead of the full link text.



Examinations and/or Inspections

Essential Findings Deviating from Normal

Exam Date

SECTION 4 – IMMUNIZATIONS

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

Vaccines (Select Type)	Date Administered (mm/dd/yy)		
Hepatitis B (HepB)	1.	2.	3.
	4.		
DTaP/DTP/DT/Td	1.	2.	3.
	4.	5.	6.
Tdap	1.		
<i>Haemophilus Influenzae</i> type b (HIB)	1.	2.	3.
	4.		
Polio (IPV/OPV)	1.	2.	3.
	4.	5.	
Pneumococcal Conjugate (PCV)	1.	2.	3.
	4.		
Rotavirus (RV1/RV5)	1.	2.	3.
Measles, Mumps, Rubella (MMR/MMRV)	1.	2.	3.
Varicella (Chickenpox), (Var, MMRV)	1.	2.	
Hepatitis A (HepA)	1.	2.	3.

Influenza (IIV/LAIV)	1.	2.	3.
	4.		
Meningococcal (MCV4, MenABCWY)	1.	2.	3.
Meningococcal B (Bexsero, Trumenba, MenABCWY)	1.	2.	3.
Human Papillomavirus (HPV)	1.	2.	3.

Additional Vaccines Specify Date & Type

Type of Vaccine(s)	Date of Vaccine(s)
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 provider office for medical waiver forms and through your local health department for nonmedical waiver forms.

History of Chickenpox Disease?

If yes, date

Yes No

Parent/Guardian refused recommended immunizations at visit.

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

Health Professional Signature

Title

Date

SECTION 5 - RECOMMENDATIONS (Required for Child Care and Head Start/Early Head Start)

Is there any defect of vision, hearing, or other condition for which the school could help by seating or other actions?

Yes No

If yes, explain

Should the child's activity be restricted because of any physical defect or illness?

Yes No

Check all that apply

Classroom

Playground

Gymnasium

Swimming Pool

Competitive Sports

Other

If yes, explain degree of restriction(s)

Other Recommendations

SECTION 6 - DENTAL EXAM OR ASSESSMENT RECOMMENDATIONS

Child's Name	Type of Service <input type="checkbox"/> Dental Exam	<input type="checkbox"/> Dental Assessment
Findings (Check all that apply) <input type="checkbox"/> No findings	<input type="checkbox"/> Treated Decay	<input type="checkbox"/> Untreated Decay
Recommendations (Check one) <input type="checkbox"/> Routine Care <input type="checkbox"/> Referral for dental treatment <input type="checkbox"/> Referral for urgent dental care		
Provider Signature		Date
Check one <input type="checkbox"/> Dentist	<input type="checkbox"/> Dental Therapist	<input type="checkbox"/> Dental Hygienist

SECTION 7 - PHYSICIAN'S SIGNATURE

Examiner's Name (Print)	Degree or License	Telephone Number
Examiner's Signature		Date
Address	City	State Zip Code MI

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 preventative and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-childcare visit 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 at regular intervals based on age.

Developed in Cooperation with the Department of Health and Human Services, Education, 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.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

CHILD INFORMATION RECORD

State of Michigan - Department of Lifelong Education, Learning, and Potential - Child Care Licensing

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)	2 nd Phone (if applicable) ()	Home Address (if not child's address)	2 nd Phone (if applicable) ()	
City	State	Zip Code	City	State
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? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, explain: (Attach additional sheets, if necessary.)				

CCL-3731 (Rev. 6/7/2024) Previous editions 7-18, 4-21, & 3-22 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.	()
5.	()	6.	()

Parent/Legal Guardian Initials:

_____ I give permission to _____, licensed by the Department of Lifelong Education, Advancement, and Potential, 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

CCL-3731 (Rev. 6/7/2024) Previous editions 7-18, 4-21, & 3-22 may be used

Tell me more about your child

Name of child: _____ Prefers to be called _____

Birthday: _____ Age _____ Allergies _____

Health Concerns: _____

What is your primary language? _____

How is your child's temperament? _____

How does your child sleep? Do they need anything to nap? Do they take naps?

How are your child's eating habits? Likes or dislikes? _____

Is your child toilet trained or potty training? _____

Does your child play well with others? _____

Who does your child live with? Siblings? Pets? _____

My child's interests are. _____

Comments? Anything else we should know? _____

WRITTEN INFORMATION PACKET DOCUMENTATION
Michigan Department of Licensing and Regulatory Affairs
Child Care Licensing Bureau

Child(ren)'s Name(s) (Last, First)	Facility's Name and License Number DC 040414788
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A written information packet has been provided at the time of enrollment. The packet included all the following information (*R 400.8146 (1-2)*):

- Criteria for admission and withdrawal.
- Schedule of operation, denoting hours, days, and holidays during which the center is open, and services are provided.
- Fee policy.
- Discipline policy.
- Food service program.
- Program philosophy.
- Typical daily routine.
- Parent notification plan for accidents, injuries, incidents, and illnesses.
- Transportation policy, if applicable.
- Medication policy.
- Exclusion policy for child illnesses.
- Notice of the availability of the center's licensing notebook.
 - The center keeps a licensing notebook containing a summary sheet, all licensing inspections and special investigation reports, and related corrective action plans for the last 5 years. The licensing notebook is available to parents/guardians during regular business hours. Reports from at least the past three years are available at www.michigan.gov/michildcare.
 - The center does not keep a licensing notebook, but internet is available onsite. Reports from at least the last three years are available at www.michigan.gov/michildcare.
- Other _____

I certify that I received all of the above items.

Parent/Guardian Signature

Date

Note: A single CCL-4340 form may be used for all children in the same family.

LARA is an equal opportunity employer/program.

PARENT NOTIFICATION OF THE LICENSING NOTEBOOK

Child Care Organizations Act, 1973 Public Act 116

Michigan Department of Licensing and Regulatory Affairs

Child Care Licensing Bureau

The center keeps a licensing notebook containing a summary sheet, all licensing inspections and special investigations, and related corrective action plans for the last 5 years. The licensing notebook is available to parents/guardians during regular business hours. Reports from at least the past three years are available at www.michigan.gov/michildcare.

The center does not keep a licensing notebook, but internet is available onsite. Reports from at least the last three years are available at www.michigan.gov/michildcare.

I have read the above statement issued by Scribbles and Giggles Day Care Center, LLC

Name of Child Care Center

Child(ren)'s Name(s):	
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Parent Name _____

Parent Signature _____ Date _____

LARA is an equal opportunity employer/program.

Scribbles and Giggles Day Care Center, LLC

STATEMENT OF VOLUNTARY CONSENT, GENERAL RELEASE OF LIABILITY, WAIVER OF CLAIMS, EXPRESS ASSUMPTION OF RISKS, AND HOLD HARMLESS AGREEMENT

I, hereby, agree as follows:

I, _____, for myself and my minor child, and my estate, heirs, administrators, executors and assigns, hereby release, discharge and hold harmless Scribbles and Giggles Day Care Center, LLC, including their respective officers, directors, employees, representatives, agents, and volunteers, for, from and against any and all liability and responsibility, whatsoever, for any loss, personal injury, or death, arising out of any injury or accident sustained by my child which was not a result of Scribbles and Giggles Day Care Center, LLC negligence, including, but not limited to, any injury such as food allergy, health issue, disability, or other matter was disclosed to Scribbles and Giggles Day Care Center, LLC in the "registration forms".

In signing this agreement, I acknowledge and represent that I have read and understand this agreement; that I sign it voluntarily and for full and adequate consideration, fully intending to be bound by the same; that I am at least eighteen (18) years of age and fully competent; and that I am the **legal guardian** of minor child participant registered under my family name.

RELEASOR/PARTICIPANT/LEGAL GUARDIAN OF MINOR PARTICIPANT:

SIGNATURE: _____ PRINT NAME: _____

DATE: _____

WITNESSES:

SIGNATURE: _____ PRINT NAME: _____

DATE: _____

Scribbles and Giggles Day Care Center, LLC
Media/Photography: Consent and Release Form

I, _____, allow my child(ren) _____

To be photographed during special events or normal day to day activities organized by Scribbles and Giggles Day Care Center, LLC.

As a parent of child(ren), I agree to the following:

-I understand that my child(ren) whose name(s) are listed below may be photographed while attending Scribbles and Giggles Day Care, LLC during normal center hours, field trips, or activities.

-I understand that these photographs may be used in center newsletters or uploaded to the Scribbles and Giggles website, Facebook, and KangarooTime.

-I give permission for my child(ren) to be photographed, or their images recorded to be uploaded to above sites.

_____ Yes, I confirm that I have read and understand, and that I agree to have my child(ren) be photographed and uploaded to the above sites.

_____ No, I do not want my child(ren) to be photographed and/or photo uploaded to any site listed above.

Signature: _____

Name(Please print): _____

Date: _____

Kangaroo Time

Parent Information

First Name: _____

Last Name: _____

Email: _____

Phone Number: _____

Home Address: _____

City: _____

Zip Code: _____

Billing Cycle: Weekly or Monthly

Child(s) Name: _____

Birthday: _____

Kangarootime

Child and Adult Care Food Program (CACFP) Formula/Food Sign-Off Statement

Scribbles and Giggles Day Care Center,

As a participant in the CACFP, we must offer to supply all infant meal food components, as developmentally appropriate, to all infants in our care. We will supply the following items to your infant:

2316

- Iron-fortified infant formula
- Iron-fortified infant cereal
- Infant foods and/or table foods in the appropriate texture for the age of your infant.

Parents/Guardians may choose to accept our supplied infant formula and/or foods or provide their own. Mothers are always welcome to breast feed on-site and/or provide expressed Parents/Guardians may provide one food component towards a reimbursable meal. Our center must supply all other meal components, as developmentally ready, to receive reimbursement.

Please check your preferences below for each meal pattern requirement.

Our center will supply the following formula and infant food:

Formula Offered by Our Center: _____
(Specific brand/type identified by center)

Parent/Guardian check your breast milk/formula preference:

- | | |
|---|--|
| <input type="checkbox"/> I want the center to provide formula to my infant | <input type="checkbox"/> I will bring iron-fortified formula for my infant |
| <input type="checkbox"/> I will come to the center to breast feed my infant | <input type="checkbox"/> I will bring expressed breast milk for my infant |

Iron-Fortified Infant Cereal offered by our center:

- Rice Barley Wheat Oat Multi-Grain

Parent/Guardian check your infant cereal preference:

- I want the center to provide iron fortified infant cereal for my infant
 I will bring iron fortified infant cereal for my infant

Food offered by our center:

- Store-bought infant foods
 Table foods at the appropriate consistency for the development of your infant

Parent/Guardian check your infant food preference:

- I want the center to provide developmentally appropriate foods for my infant
 I will bring foods for my infant

If parent/guardian is supplying any breast milk, formula, or infant foods: Specify what we may feed your infant if they are still hungry after they are fed what has been supplied for the day:

Infant Name: _____ Birth Date: _____
 Parent/Guardian Signature: _____ Date Signed: _____

Non-Discrimination-Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; or (2) fax: (833) 256-1665 or (202) 690-7442; (3) or email: program.intake@usda.gov.

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 _____

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

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	___ BiWeekly										
		___ Monthly	___ Weekly										
		___ 2xMonth											
Institution Official Signature: _____		Approval Date: _____											
		<p style="text-align: center;"><u>APPROVED CATEGORY</u></p> <table border="0"> <tr> <td>Categorical Eligibility</td> <td>Foster</td> <td>FIP</td> <td>FAP</td> <td>FDPI</td> </tr> <tr> <td>Other Household</td> <td>Free</td> <td>Reduced</td> <td colspan="2">Paid</td> </tr> </table>		Categorical Eligibility	Foster	FIP	FAP	FDPI	Other Household	Free	Reduced	Paid	
Categorical Eligibility	Foster	FIP	FAP	FDPI									
Other Household	Free	Reduced	Paid										

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



Enrollment Agreement – Child Development and Care (CDC) Program

In addition to an enrollment agreement, licensed providers are required to keep daily time and attendance records that document each child's *actual* daily care begin and end time and include a daily parent certification (signature or initials). See the Child Development and Care Handbook for time and attendance requirements at www.michigan.gov/childcare.

Provider or Program Name: _____ **Provider ID:** _____

Child's Name: _____

Total Number of Authorized Hours from CDC - Form DHS-198 (If known) : _____

- If the child has more than one provider, CDC subsidy payment cannot exceed maximum authorized hours for all providers.

Effective Date of this Schedule: _____

Child's Enrollment (the days and times agreed upon between the parent and provider). Use both boxes per day if there are multiple daily in/out times such as before and after school.

Days	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Begin Time							
AM/PM							
End Time							
AM/PM							

Agreed total enrolled hours for this provider: _____

Comments (i.e., Explain if varying schedules are needed):

I expect to have more than one provider assigned to my child: _____ Yes _____ No

Parent Acknowledgements:

- The above enrolled schedule is correct and if the enrolled schedule changes, a new Enrollment Agreement should be completed.
- If more than one provider is assigned to a child, one or both providers may not receive full payment. It is also possible that one provider will receive no payment and the parent may be responsible for payment.
- I may be responsible for any child care charges not paid by the Department.
- A new Enrollment Agreement must be completed if an enrolled schedule change extends beyond two weeks.

Parent/Substitute Parent Signature _____ **Date** _____