Enrollment Packet Checklist

__ Completed Application

__ Parent Identification Card

__ Parent Social Security Card

__ Completed IES Form

__ Child Shot Records

******All items must be complete before the child can be enrolled in the center******

(Intentionally Left Blank)

MPPA Family Childcare Inc
Enrollment Form

Entrance Date: _____________ Withdrawal Date: ______________Referred By: ___________________

Child's Name: _________________________ Sex: ___ Age: ____ Date of birth: ____________

Home Address (Street): ____

City: _________________________________ State: ___________________ Zip: ___________

Home Phone Number: _____________________________

Father's Name: _________________________ Cell Phone Number and Carrier: _______________________

Father's Home Address (if different from child's) Street: _______________________________

City: __________________________________ State: ___________________ Zip: ___________

Father's Social Security Number: ___________________

Father's Place of Employment: ___________________________ Work Phone: ______________

Father's Email Address: ____

Mother's Name: _________________________ Cell Phone Number and Carrier: _______________________

Mother's Home Address (if different from child's) Street: _______________________________

City: __________________________________ State: ___________________ Zip: ____________

Mother's Social Security Number: ________________________

Mother's Place of Employment: ___________________________ Work Phone: ______________

Mother's Email Address: ____

Child's Living Arrangements (check one): ( ) Both Parents; ( ) Mother; ( ) Father; ( ) Other:_____________

Child's Legal Guardian(s) (check one): ( ) Both Parents; ( ) Mother; ( ) Father; ( ) Other:_______________

The child may be released to the person(s) signing this agreement or to the following:

Name: _________________________________ Cell Phone Number: _______________________

Relationship to Child: ________________ Relationship to Parent(s) or Guardian: ______________

Name: _________________________________ Cell Phone Number: ________________________

Relationship to Child: ________________ Relationship to Parent(s) or Guardian: ______________

Name: _________________________________ Cell Phone Number: ________________________

Relationship to Child: ________________ Relationship to Parent(s) or Guardian: ______________

Name: _________________________________ Cell Phone Number: ________________________

Relationship to Child: ________________ Relationship to Parent(s) or Guardian: ______________

Name: _________________________________ Cell Phone Number: ________________________

Relationship to Child: ________________ Relationship to Parent(s) or Guardian: ______________

MPPA Family Childcare Inc
Enrollment Form

Emergency Contact

Persons to contact in the case of emergency when parent or guardian cannot be reached:

Name: ____________________________ Telephone Number: ____________________________

Name: ____________________________ Telephone Number: ____________________________

Name: ____________________________ Telephone Number: ____________________________

Name of Public or Private School child attends, if any: ___________________________________

Child's doctor or clinic name: ____

Doctor/clinic phone #: _____________________________________

My child has the following special needs: ____

____

____

The following special accommodation(s) may be required to most effectively meet my child's needs while at the center: ____

____

____

My child is currently on medication(s) prescribed for long-term continuous use and/or has the following pre-existing illness, allergies, or health concerns: ____

____

EMERGENCY MEDICAL AUTHORIZATION

Should (child's name) ____________________________ Date of birth: ______________________________

suffer an injury or illness while in the care of (Facility name) and the facility is unable to contact me (us) immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. I (We) shall assume responsibility for payment for services.

Parent/Guardian: ______________________________________

Signature: ____

Date: _________________

Facility Administrator/Person-In-Charge: Pamela Lewis

Signature: Pamela Lewis **Date: __________________________**

MPPA Family Childcare Inc
Enrollment Form

Parental Agreements with Child Care Facility

MPPA Family Childcare Center Inc. 1 and 2 agrees to provide child care for

__________________________ on ______________________ ______ (am/pm) to ________(am/pm)

(Name of Child) (# of Days of Week)

from _________________________ to ________________________.

(Month/Year) (Month/Year)

My child will participate in the following meal plan (circle applicable meals and snacks):

Breakfast / Morning Snack / Lunch

Afternoon Snack / Dinner / Evening Snack

The ONLY medication that will be administered at MPPFCCINC is a EpiPen in case of emergency

My child will not be allowed to enter or leave the facility without being escorted by the parent(s), person over 18 authorized by parent (s), or facility personnel.

I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, e.g., address, telephone numbers, work location, emergency contacts, child's physician, child's health status, infant feeding plans and immunization records, etc.

The facility agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, etc., which include my child.

The facility agrees to obtain written authorization from me before my child participates in routine transportation, field trips, special activities away from the facility, and water-related activities occurring in water that is more than two (2) feet deep.

I authorize the child care facility to obtain emergency medical care for my child when I am not available.

I have received a copy and agree to abide by the policies and procedures for

MPPA Family Childcare Center Inc. 1 and 2

I understand that the facility will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is encouraged in facility activities.

Signed: ____ Date: _______________________

(Parent/Guardian)

Signed: Pamela Lewis Date: ______________________

(Facility Administrator)

MPPA Family Childcare Inc
Enrollment Form

MPPA Family Childcare Center Inc. 1 and 2

Parents or Guardian's

Notice of No Liability Insurance and Acknowledgement

I understand that I am being informed in writing by signing this acknowledgement that this facility, MPPA Family Childcare Center Inc 1 & 2, does not carry liability insurance sufficient to protect my child/children in the event of an injury, etc. MPPA Family Childcare Center Inc. 1 and 2 shall not be responsible for providing or paying for the child's health care. I agree that neither I, nor my child will bring any claims of any kind against MPPA Family Childcare Center Inc. 1 and 2 and its employees, as a result of injuries, expenses or damages that I or my child may suffer in any way related to the use of the facilities, toys, other children and/or teachers, whether such claims are known or unknown or arise in the future.

______________________________ ______________

Parents/guardian's Signatures **Date**

______________________________ ______________

Parent/guardian (Print Names) **Date**

Pamela Lewis ______________

(Facility Administrator) **Date**

MPPA Family Childcare Center Inc. 1 and 2

Parent Contract with MPPA

- Before any medication is dispensed to my child, I will provide a written authorization, which includes: date, name of the child, name of medication, prescription number, if any, dosages, date and time of day of any medications is to be given. Medicine must be in the original container with my child's name marked on it.
- My child will not be allowed to leave the facility without being escorted by an authorized parent, guardian or facility personnel.
- The facility agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, etc. which include my child.
- I authorize the facility to obtain emergency medical care for my child when I am not available
- I have received a copy of the Parent Handbook and agree to abide by the policies and procedures for MPPA Family Childcare Center Inc. 1 or 2
- I acknowledge that it is my responsibility to keep my child's records current to reflect any significant changes as they may occur, e.g, telephone numbers, work location, emergency contacts, child's physician, child's health status, immunization and feeding plans.
- **PARENTS MUST PROVIDE A WRITTEN NOTICE, 2 WEEKS PRIOR TO LEAVING, OF THEIR INTENT TO WITHDRAW THEIR CHILD(REN) FROM THE FACILITY**
- Prayer and Christian - based instruction are incorporated within the curriculum at both centers
- I understand that the center will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is encouraged in facility activities.

Signed: ___________________________ Date: ___________________

Parent/ Guardian

Signed: *Pamela Lewis*

(Facility Administrator)

MPPA Family Childcare Inc
Enrollment Form

Vehicle Emergency Medical Information

Child's Name _________________________________ Date of Birth _______________

Address ____

Father's Name ____

Home Phone ______________________________________ Work Phone____________

Mother's Name____

Home Phone ______________________________________ Work Phone ____________

Person to notify in an emergency and parents cannot be reached:

Name _____________________________________ Phone_______________________

Child's Doctor ______________________________ Phone_______________________

Medical facility the center uses: Children's Healthcare of Atlanta / Rockdale Medical Center

Address: 1510 Hudson Bridge Rd, Stockbridge, GA. 30281 or 1412 Milstead Ave, Conyers, GA 30012

Child's Allergies____

Current prescribed medication____

Child's special needs and conditions____

In the event of an emergency involving my child, and if MPPAFCCINC1&2 cannot get in touch with me, I hereby authorize any needed emergency medical care. I further agree to be fully responsible for all medical expenses incurred during the treatment of my child.

Child's Name____

Signature (Parent/Guardian) ____

Witness By Pamela Lewis Date______________________

(Facility Administrator)

M. P. P. A.

Standard Photo and Video Release Form for Minor Children

I hereby authorize **MPPA Family Childcare Center Inc. 1 and 2** to publish the photographs and videos taken of me and/or the undersigned minor children, and their names for use in **MPPAFCCINC** printed publications, websites, and for training purposes.

I release **MPPAFCCINC from any expectation of confidentiality** for the undersigned minor children and myself and attest that I am the parent or legal guardian of the children listed below and that I have the authority to authorize **MPPAFCCINC** to use their photographs, videos, and names.

I acknowledge that participation in publications and websites produced by **MPPAFCCINC** is voluntary, neither the minor children nor I will receive any financial compensation.

I further agree that participation in any publication and websites produced by **MPPAFCCINC** confers no rights of ownership whatsoever. I release **MPPAFCCINC,** its employees and its contractors from liability for any claims by me or any third party in connection with my participation or the participation of the undersigned minor children.

○ I do not authorize MPPAFCCINC to publish the photographs and videos taken of me and/or the undersigned minor children, and their names for use in MPPAFCCINC printed publications, websites, and for training purposes.

Signature: ________________________ Date: _______________

Printed Name: _________________________

Street Address: ____

City/State/Zip: ____

Names and Ages of Minor Children:

Name: _____________________________ Age: _______

Name: _____________________________ Age: _______

Name: _____________________________ Age: _______

Name: _____________________________ Age: _______

Name: _____________________________ Age: _______

MPPA Family Childcare Inc
Enrollment Form

Safe Sleep Practices Policy

Child's name: ___________________________ Date of birth: _______________

Parent/Guardian name: ____

Safe Sleep Practices/Policies:

1) Infants will be placed on their backs in a crib to sleep unless a physician's written statement authorizing another sleep position for that infant is provided. The written statement must include how the infant shall be placed to sleep and a time frame that the instructions are to be followed.

2) Cribs shall be in compliance with CPCS and ASTM safety standards. They will be maintained in good repair and free from hazards.

3) No objects will be placed in or on the crib with an infant. This includes, but is not limited to, covers, blankets, toys, pillows, quilts, comforters, bumper pads, sheepskins, stuffed toys, or other soft items.

4) No objects will be attached to a crib with a sleeping infant, such as, but not limited to, crib gyms, toys, mirrors and mobiles.

5) Only sleepers, sleep sacks and wearable blankets provided by the parent/guardian and that fit according to the commercial manufacturer's guidelines and will not slip up around the infant's face may be worn for the comfort of the sleeping infant.

6) Individual crib bedding will be changed daily, or more often as needed, according to the rules. Bedding for cots/mats will be laundered daily or marked for individual use. If marked for individual use, the sheets/covers must be laundered weekly or more frequently if needed. This facility will adhere to the above practices throughout the center.

7) Infants who arrive at the center asleep or fall asleep in other equipment, on the floor or elsewhere, will moved to a safety-approved crib for sleep.

8) Swaddling will not be permitted, unless a physician's written statement authorizing it for a particular infant is provided. The written statement must include instructions and a time frame for swaddling the infant.

9) Wedges, other infant positioning devices and monitors will not be permitted unless a physician's written statement authorizing its use for a particular infant is provided. The written statement must include instructions on how to use the device and a time frame for using it.

I acknowledge that the director or designee has advised me of the safe sleep practices followed by the facility.

Signature: ___________________________________ **Date:** ________________

MPPFCCINC

Rules and Regulations Parent Handbook (Effective date 1/03/2024)

I, ___________________________, by my signature below attest that I have received a copy of these rules and regulations. I further attest that I have read and understand these policies and rules and I agree to abide by them. Failure to abide to the policies and procedures of MPPAFCCINC D.B.A MPPA Family Childcare Center 1 & 2 will result in child dismissal from the center.

________________________ ___________________

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

____

Printed Name (Parent/Guardian)

MPPA Family Childcare Center, Inc. 1 & 2

Dear parent/guardian,

MPPAFCCINC is pleased to offer **MyProcare**, a free online portal for you to access account information and easily pay tuition. MyProcare is safe, secure and created with your convenience in mind.

Log in today!

1. Go to the link below:
https://www.myprocare.com/Default/Index?aWtuPTU3NTQ5Mjk3Nzg=

2. Enter your email address (the email you have on file with MPPA) and choose ***Go.***

3. Enter the confirmation code sent to your email, choose a password, and press ***Go.***

4. Then you may:
   a. View your child's timecard, immunizations and more.
   b. Use the ***Pay*** button to make a payment with your card.

Thank you!

MPPA and MyProcare

IMPORTANT INFORMATION REGARDING MPPA BILLING POLICY

1. **The initial tuition payment is due on the day your child(ren) enrolls at MPPA**
2. **ALL further Tuition Payments are due every Friday before the next week of childcare; payment is due even if the center is closed or your child does not attend on Friday**
3. **The total weekly payment amount must be made to avoid any late fees or denied entry; If your pay period is biweekly or monthly, you must pay your tuition in advance so that there is no balance on your account.**
4. **A late fee of $30.00 will be charged if the weekly tuition payment is not paid by the close of business on Friday evening**
5. **NO ENTRY WILL BE PERMITTED ON MONDAY IF THE TUITION HAS NOT BEEN PAID – NO EXCEPTIONS**
6. **A $5 fee, per child, will be charged if your child(ren) is not signed in or out on both the COMPUTER AND the SIGN-IN/OUT SHEET(CAPS Only)**
7. **Time overage and any other fees are due with the next tuition payment**
8. **A Slot Holding Fee of $75 is charged anytime your child is out for a week for any reason**

What causes overages?

- **Childcare services that exceed 8 hours(PT) and 10 hours(FT) on any day**
- **Late pick up after the center closes @ $5 per minute**
- **The rate is $20 per child per hour after 10 hours per day**
    - **Ex. The child is in attendance for 10hrs15min = $20**
    - **Ex. The child is in attendance for 11hrs10mins = $40**

Please use MyProcare.com to make all online payments. You can also update account information and add/remove authorized people on the pickup list.

MPPA Family Childcare Center 1

2952 Hwy 138 SE

Stockbridge, Ga. 30236

Phone:678-545-6772

Fax: 770-681-0325

Email: MsPamsPreciousAngelsFCC1@gmail.com

MPPA Family Childcare Center 2

2125 Old Salem Rd.

Conyers, Ga. 30013

Phone: 770-679-9199

Fax: 770-648-7216

Email: MsPamsPreciousAngelsFCC2@gmail.com

Website: MsPamsPreciousAngels.org

MPPA Family Childcare Inc
Enrollment Form

CACFP Meal Benefit Income Eligibility Statement Ms Pam's Precious Angels Inc. 2

PART I: Child(ren) or Adult enrolled to receive day care

Name: (Last, First and Middle Initial)	Date of Birth (Optional) MM/DD/YY	SNAP, TANF, or FDPIR case number, or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. **Note**: Do not use EBT numbers. Write case number and proceed to Part III.	Children in Head Start, foster care and children who meet the definition of migrant, runaway, or homeless are eligible for free meals. Check (✓) all that apply. **(See definitions in FAQs)** Head Start	Foster Child	Migrant	Runaway	Homeless
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐

PART II: Report income for ALL Household Members (Skip this step if participant is categorically eligible as documented in Part I.)
Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information

A. Child Income - Sometimes children in the household earn or receive income. Please indicate the TOTAL income received by child household members listed in PART I here. All children income/How often? $_______________/_______________

B. Other Household Members. **List all household members even if they do not receive income. Also, list the adult participant if he/she did not meet eligibility in Part I.** For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. **If they do not receive income from any source, write '0'. If you enter "0" or leave any field blank you are certifying (promising) there is no income to report.**

Name of Other Household Members (First and Last)	1. Earnings from work before deductions / How often	2. Welfare, child support, alimony / How Often	3. Social Security, pensions, retirement / How Often	4. All other income / How Often
(Example) Jane Smith	$ 200/week	$ 150/twice a month	$ 100/month	$_____/_______
1. ______________________	$ ________/________	$ ________/________	$ ________/________	$ ________/________
2. ______________________	$ ________/________	$ ________/________	$ ________/________	$ ________/________
3. ______________________	$ ________/________	$ ________/________	$ ________/________	$ ________/________
4. ______________________	$ ________/________	$ ________/________	$ ________/________	$ ________/________
5. ______________________	$ ________/________	$ ________/________	$ ________/________	$ ________/________

C. Total Household Members (Adults and Children) listed in Part I and Part II ___________

D. Social Security Number. If income is listed or completed in Part II, the adult completing the form must also list the last four digits of his or her Social Security Number or check the "I don't have a Social Security Number" box below. (See Privacy Act Statement on next page). **Failure to complete this section, if income is listed, will result in the denial of free or reduced eligibility.**
Last four Digits of Social Security Number XXX-XX___________ ☐ I do not have a Social Security Number

PART III: Enrollment Information: *Children Only*

My child is normally in attendance at the facility between the hours of _______[am/pm] to _____[am/pm]. ☐ (✓) Check here if only before/after school care is provided.

Circle the days your child will normally attend the center: **Sunday Monday Tuesday Wednesday Thursday Friday Saturday**

Circle the meals your child will normally receive while in care: **Breakfast AM Snack Lunch PM Snack Supper Evening Snack**

PART IV: Signature

*I certify that all information on this form is true and that **all** income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposefully give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted. This signature also acknowledges that the child(ren) or adult listed on the form in Part I are enrolled for care. **If not completed fully and signed, the participant will be placed in the Paid category**.*

Signature: X ______________________________ **Print Name:** ______________________ **Date:** ______________
Address: ______________________________ **City:** __________________ **State:** _______ **Zip:** ___________ **Phone:** ____________________

PART V: Participant's Ethnic and Racial Identities (optional)

Check (✓) one ethnic identity:
☐ Hispanic/ Latino ☐ Not Hispanic/ Latino

Check (✓) one or more racial identities:
☐ Asian ☐ White ☐ Black or African American ☐ Indian or Alaska Native ☐ Hawaiian or other Pacific Islander

Official Use Only Section for QCC Staff: Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12

(A) Total income: ______________________ per ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Year

(B) Household Size: _________ **(C) Categorical Eligibility**: ☐ (Check if applicable) **(D) Eligibility**: ☐ Free ☐ Reduced ☐ Paid

(E) Day Care Homes Only: Check one ☐ Tier I ☐ Tier II **(F) Time Period:** ______________________________

When more than one person is performing CACFP duties, there must be at least two signatures on this form: one signature from the Determining Official (the official who determined initial income classification) and one signature from the Confirming Official (the official who verified the form's accuracy).

Determining Official's Signature: ______________________ **Date**: _________ **Confirming Official's Signature** ______________________ **Date**: ___________

Follow Up Official's Signature: ______________________________ **Date**: ______________________

(Intentionally Left Blank)