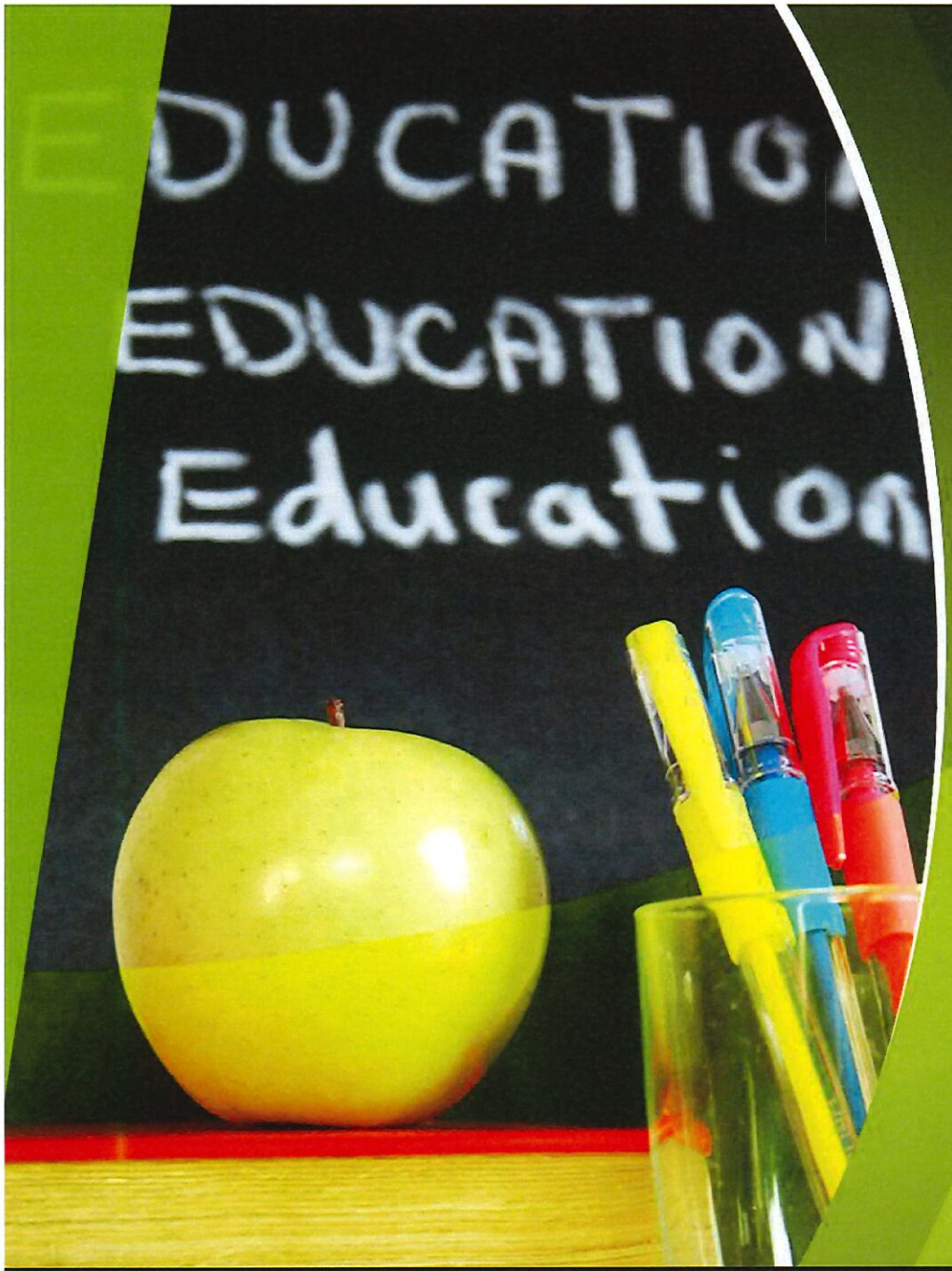

Tangie's

Just Like Mommy Childcare Center

Enrollment Information

West Milwaukee Location

Provider Number (9000584129)

Location Number 002

1627 South 44th Street.

West Milwaukee, WI 53214

Phone: 414-384-6655

Fax: 414-384-6675

Dear Potential Parent/Guardian

Welcome to Tangie's Just Like Mommy Childcare Center!

I believe that quality early care and education is a partnership between parents and provider. At Tangie's Just Like Mommy Childcare Center, it is our mission to partner with parents, and to provide Infants, Toddlers and school aged children with age and developmentally appropriate activities and materials in a safe, loving environment where they are free to explore and learn.

TJLM Childcare Center is owned and operated by Tangie Cokes, and family with over 11 years of providing childcare with locations in West Milwaukee, Milwaukee, and West Allis. With our experienced staff, your child will feel our energy and devotion because we believe that at this developmental stage, children should receive loving, responsive relationships with caregivers, based on respect for the child and his or her family. TJLM Childcare Center, your child will have the opportunity to explore and grow, create and discover, build relationships with his or her peers, and become confident learners.

Thank you for choosing Tangies Just Like Mommy Childcare Center. As you know, in the first three years of your child's life, he/she will go though some incredible developmental stages. Observing a child's journey through these stages never ceases to fill us with awe and wonderment. We are looking forward to joining you on your child's amazing journey!

Tangie's

Just Like Mommy Childcare Center

Provider Agreement

1. TJLM Childcare center is open from 5:30am to 11:00pm Monday through Friday. We must have a weekly schedule for staffing purposes. If you deviate from the schedule provided to us, you must call and speak directly to the Director or owner. Arriving 15 minutes after your scheduled time to drop of your child, will result in him/her possibly being turned around.

2. Picking up your child 15 minutes late or more will result in a late pick up fee of $15 for every 15 minutes and this is per child. This fee, must be paid before your child can return to the center. If you go over your allowed hours a week/month, any hour over will be a $7 fee per hour.

3. The center must be notified if a schedule is changing or children will not attend for the day.

4. NO child can be in our center more than 12 hours per day. All hours **over 9** are considered extended stay care hours and additional payment of $10 per hour is due per child in advance.

5. Monthly payments for private pay and (MYWI EBT CARD HOLDERS) must be made on the 1st of every month and or for new families before childcare services are rendered. All daycare services will cease on the 3rd of the month if payment is not submitted to provider. Payments through MYWI EBT can be made 7 days a week/24 hours a day. There are no refunds once payment is made to us for **ANY** reason. No child can attend w/o payment. Private Pay Customers payments must be made in advance the Friday before the week of care. NO EXCEPTIONS. Fee is due for days contracted even if your child does not attend.

6. See **Tuition Fee Schedule for Transportation fee rates**. Once this fee is paid it will not be refunded.

7. Cash or Credit Only

8. We are not responsible for toys, cellphones, tablets or any devices brought from home and we WILL NOT reimburse any person for these items. NO CHILDREN ARE ALLOWED CELLPHONES while in our care. They will be confiscated.

9. We do not provide diapers, wipes, or formula. **PARENTS MUST BRING THIS**. We will not care for children without adequate supplies to get them through a day of care.

10. Each child 2 or over must bring a sleeping blanket and a change of clothes. These items should be taking home on Friday, properly washed and returned on Monday.

11. Each infant should have everything in their diaper bag needed to get them through a day of care.

Provider Agreement- Continued

12. All parents must be signed up for our Brightwheel App
13. NO child can start without shot records, child health report and all child enrollment forms completed.
14. We do not provide sick childcare. You may not send/ bring your child to daycare sick, i.e. fever, vomiting, diarrhea, lice, chicken pox, strep throat, ringwork, or a bad cold with excessive running nose.
14. Parent's/Guardians must keep us updated with current phone numbers, addresses, work info and email addresses. In addition, blatantly choosing to ignore or return our calls for any reason while your child is in our care will result in termination of care and we will contact CPS if deemed necessary (we are mandated reporters).
15. Anyone scheduled to pick up your child must have a photo id and be listed on file.
16. All Parents Are Responsible for signing children in and out daily

_____	_____	_____
Parent/Guardian Printed Name	Parent/Guardian Signature	Date

Payment: Provider # 9000584129 |002

Revised 01/10/2020

Scheduled # of days	Infant & Toddlers (4wks – 2.5Yrs)	Toddlers & Early Preschool (2.5yrs – 3Yrs)	Preschoolers (3.5Yrs – 5Yrs)	School-Agers (6Yrs – 12Yrs)
		Full Day = 5 to 9 Hours		
1 full	60	55	50	45
2 full	120	110	100	90
3 full	180	165	150	135
4 full	240	220	200	180
5 full	300	275	250	225
		Half Day = 4 hours a day		
1 half	49	43	39	36
2 half	98	86	78	72
3 half	147	129	117	108
4 half	196	172	156	144
5 half	245	215	195	180

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

http://dcf.wisconsin.gov

CHILD CARE ENROLLMENT

Use of form: Use of this form is mandatory for Family Child Care Centers to comply with DCF 250.04(6)(a)1. Failure to comply may result in issuance of a noncompliance statement. This form may also be used by Group Child Care Centers and Day Camps to comply with DCF 251.04(6)(a)1. and DCF 252.41(4)(a)1. respectively. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian shall fill out the form completely, sign it and submit it to the center prior to the child's first day of attendance. Information on this form shall be kept current. When enrolling a child under two years of age, a completed *Intake for Child Under 2 Years* form must also be on file prior to the child's first day of attendance.

CHILD INFORMATION

Name (Last, First, MI)	Birthdate (mm/dd/yyyy)	First Day of Attendance

PARENT OR GUARDIAN – All parents / guardians are permitted to visit during center hours and are allowed to pick up the child unless access is prohibited or restricted by a court order. Attach court order, if any. If the child resides at multiple locations, the department recommends the provider obtain and attach a schedule.

a. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care

Home Address (Street, City, State, Zip)	Does child reside at this location? ☐ Yes ☐ No	Place of Employment and Work Phone No.

b. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care

Home Address (Street, City, State, Zip)	Does child reside at this location? ☐ Yes ☐ No	Place of Employment and Work Phone No.

AUTHORIZED PERSONS – Persons other than parents / guardians who are authorized to pick up the child or accept the child if dropped off. If no one, write "None."

a. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.

b. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.

EMERGENCY CONTACT – The person to be notified in an emergency when parents / guardians cannot be reached.

☐ Yes ☐ No This person is authorized to pick up the child.

Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.

PHYSICIAN OR MEDICAL FACILITY

Name	Address (Street, City, State, Zip Code)	Telephone Number

AUTHORIZATIONS

☐ Yes ☐ No I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.
☐ Yes ☐ No I have had an opportunity to review the policies of this child care center and a summary of the Wisconsin Rules for Licensing Child Care Centers.
☐ Yes ☐ No I give permission for my child to participate in ☐ Transported ☐ Walking field trips and other activities during operating hours.
☐ Yes ☐ No I have been informed of the number of pets in the center and their degree of contact with the enrolled children. Note: If pets are added after a child is enrolled, parents shall be notified in writing prior to the pet's addition to the center.

SIGNATURE – Parent or Guardian	Date Signed

HEALTH HISTORY AND EMERGENCY CARE PLAN

Use of form: This form is required for family and group child care centers and day camps to comply with DCF 250.04(6)(a)1. and 250.07(6)(L)5., DCF 251.04(6)(a)6. and 251.07(6)(k)5., and DCF 252.44(6)(g) of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

CHILD INFORMATION

Name (Last, First, MI)	Address – Home (Street, City, State, Zip Code)	
Telephone Number	Birthdate (mm/dd/yyyy)	Date – First Day of Attendance (mm/dd/yyyy)

PARENT / GUARDIAN INFORMATION

Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular
Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular

PHYSICIAN / MEDICAL FACILITY INFORMATION

Name – Physician	Address – Medical Facility	Telephone Number

SUNSCREEN / INSECT REPELLENT AUTHORIZATION

If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 251.07(6)(f)2., authorizations shall be reviewed every 6 months and updated as necessary. Per DCF 250.07(6)(f)2.a., Authorizations shall be reviewed periodically and updated as necessary.

	Brand Name	Ingredient Strength
☐ Yes ☐ No I authorize the center to apply sunscreen to my child. ☐ Yes ☐ No I authorize the center to allow my child to self-apply sunscreen.		
☐ Yes ☐ No I authorize the center to apply repellent to my child. ☐ Yes ☐ No I authorize the center to allow my child to self-apply repellent.	Brand Name	Ingredient Strength

HEALTH HISTORY AND EMERGENCY CARE PLAN

If available, attach any health care plan information from the child's physician, therapist, etc.

1. Check any special medical condition that your child may have.

☐ No specific medical condition
☐ Asthma
☐ Diabetes
☐ Gastrointestinal or feeding concerns including special diet and supplements
☐ Cerebral palsy / motor disorder
☐ Epilepsy / seizure disorder
☐ Any disorder including Cognitively Disabled, LD, ADD, ADHD, or Autism
☐ Other condition(s) requiring special care – Specify.

☐ Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.
☐ Food allergies – Specify food(s).

☐ Non-food allergies – Specify.

2. Triggers that may cause problems – Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication* should be attached to this form. Note: group child care centers and day camps may use their own form.

5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.
   a.
   b.
   c.

6. When to call parents regarding symptoms or failure to respond to treatment.

7. When to consider that the condition requires emergency medical care or reassessment.

8. Additional information that may be helpful to the child care provider.

SIGNATURE – Parent or Guardian	Date Signed (mm/dd/yyyy)

Review dates: _____ _____ _____ _____ _____

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

dcf.wisconsin.gov/

CHILD HEALTH REPORT – CHILD CARE CENTERS

Use of form: Use of this form is voluntary; however, completion of this form meets the requirements of DCF 202.08(4), DCF 250.07(6)(L)3., and DCF 251.07(6)(k)3. Failure to comply with these rules may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months thereafter. Except for a school-aged child, each child 2 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years thereafter. The parent / guardian shall give this form to the physician, physician assistant or HealthCheck provider to be completed, signed and dated. The licensee shall obtain a copy for the child's record. Note: Children are also required to have on file at the child care center documentation of immunizations; it may be helpful if the parent / guardian were to include a copy of the child's immunization record when submitting this form to the child care center.

PARENT OR GUARDIAN – Complete this section.

Name – Child (Last, First, MI)	Birthdate – Child (mm/dd/yyyy)

Address – Child (Street, City, State, Zip Code)

Name – Parent or Guardian (Last, First, MI)

Address – Parent or Guardian (Street, City, State, Zip Code)

HEALTH PROFESSIONAL – Complete this section.

Instructions for feeding and care of child with special problems, including allergies – Specify (attach information as necessary).

☐ Yes ☐ No Does the child have a milk allergy? If "Yes", identify the recommended milk substitute.

Date of most recent blood lead test: _____ (mm/dd/yyyy). Note: Children on Medicaid are required to be tested at around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented. Lead testing is optional for children who are not on Medicaid.

Immunization(s) not to be administered to child due to medical reason(s) – Specify.

AUTHORIZATION

I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.

Name – MD, PA or HealthCheck Provider (type or print)	Address (Street, City, State, Zip Code)

SIGNATURE – MD, PA or HealthCheck Provider	Date of Examination

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

STATE OF WISCONSIN

Transportation Permission – Child Care Centers

Use of form: Use of this form is voluntary. However, completion of this form will help ensure compliance with portions of DCF 250.08, DCF 251.08 and DCF 252.09 of the Wisconsin Administrative Codes regarding regularly scheduled, center-provided / center-contracted transportation of children in care to and from the center. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian should complete this form for placement in the child's file at the center and update the information as needed. The center shall maintain the completed form in the child's file for the duration of the child's enrollment. Note: A copy of this form shall be carried in the vehicle when transporting the child. If the child has special health care needs, also include a copy of CFS-2345, Health History – Child Care Centers.

A. CHILD INFORMATION

Name	Address – Home (Street, City, State, Zip Code)

☐ Yes ☐ No Does the child have any special health care needs? If "Yes", attach the department form, "Health History – Child Care Centers."

B. PARENT / GUARDIAN INFORMATION Provide information where the parent / guardian may be reached while the child is in care.

1. Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular
Address (Street, City, State, Zip Code)			
2. Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular
Address (Street, City, State, Zip Code)			

C. EMERGENCY CONTACT INFORMATION Provide information on the person to contact if the parent / guardian cannot be reached.

Name	Address (Street, City, State, Zip)	Telephone Number

D. AUTHORIZED DESTINATIONS / PERSONS INFORMATION

	Address Child Transported From (Street, City)	Address Child Transported To (Street, City)	Person Authorized to Receive Child
1.			
2.			
3.			
4.			

Procedure to follow when parent / guardian or authorized adult is not at destination to receive child – Specify.

E. CHILD'S HEALTH CARE PROVIDER INFORMATION

Name – Physician	Address (Street, City, State, Zip Code)	Telephone Number

F. AUTHORIZATION

1. ☐ Yes ☐ No I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.
2. ☐ Yes ☐ No I hereby give permission for my school-aged child to enter a building unescorted.

SIGNATURE – Parent / Guardian	Date Signed

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education
DCF-F (CFS-0058) (R. 02/2009)

STATE OF WISCONSIN

Field Trip Or Other Activity Notification / Permission – Child Care Centers

Use of form: Use of this form is voluntary; however, completion of this form meets the requirements of DCF 250.04(6)(a)2., DCF 251.04(4)(a)4. and 251.04(6)(a)4., and DCF 252.41(4)(a)4. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes]. This form may be used both to notify parents of the specific date, time and destination of field trips which require the use of a vehicle and to obtain parental authorization for a child to participate in and be transported to and from a field trip. Note: The Child Care Enrollment form also contains a section for obtaining authorization from a parent to participate in field trips if the center chooses to use that form.

Instructions: Complete the form and submit to the parents / guardians for their signature prior to the date of the upcoming field trip.

Name – Center or Day Camp	Name – Child

Date(s) – Field Trip or Other Activity	Departure Time	Estimated Return Time

Destination	Type of transportation:
	☐ Center vehicle ☐ Parent / volunteer vehicle ☐ Contracted vehicle ☐ Public transportation

Name – Center or Day Camp

I authorize the facility listed above to take my child on a field trip or other activity on the date(s) indicated.

SIGNATURE – Parent or Guardian	Date Signed

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-04020L (Rev. 06/2017)

STATE OF WISCONSIN
Wis. Stat. §§ 252.04 and 120.12 (16)

STUDENT IMMUNIZATION RECORD

INSTRUCTIONS TO PARENT: COMPLETE AND RETURN TO SCHOOL WITHIN **30 DAYS AFTER ADMISSION.** State law requires all public and private school students to present written evidence of immunization against certain diseases **within 30 school days of admission.** The current age/grade specific requirements are available from schools and local health departments. These requirements can be waived only if a properly signed health, religious or personal conviction waiver is filed with the school. The purpose of this form is to measure compliance with the law and will be used for that reason only If you have questions regarding immunizations, or how to complete this form contact your child's school or local health department.

Step 1 **PERSONAL DATA** **PLEASE PRINT**

Student's Name	Birthdate (Mo/Day/Yr)	Gender	School	Grade	School Year

Name of Parent/Guardian/Legal Custodian	Address (Street, City, State, Zip)	Telephone Number ( )

Step 2 **IMMUNIZATION HISTORY**

List the MONTH, DAY, AND YEAR your child received each of the following immunizations. DO NOT USE A (√) OR **(X)** except to answer the question about chickenpox, Tdap, or Td. If you do not have an immunization record for this student at home, contact your doctor or public health department to obtain it.

TYPE OF VACCINE*	FIRST DOSE Mo/Day/Yr	SECOND DOSE Mo/Day/Yr	THIRD DOSE Mo/Day/Yr	FOURTH DOSE Mo/Day/Yr	FIFTH DOSE Mo/Day/Yr
DTaP/DTP/DT/Td (Diphtheria, Tetanus, Pertussis)					
Adolescent booster (Check appropriate box) ☐ Tdap ☐ Td					
Polio					
Hepatitis B					
MMR (Measles, Mumps, Rubella)					
Varicella (Chickenpox) Vaccine Vaccine is required only if your child has not had chickenpox disease. See below:					

Has your child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known:
☐ YES _____ year (Vaccine not required)
☐ NO or Unsure (Vaccine required)

Has your child had a blood test (titer) that shows immunity (had disease or previous vaccination) to any of the following? (Check all that apply)
☐ Varicella ☐ Measles ☐ Mumps ☐ Rubella ☐ Hepatitis B
If YES, provide laboratory report(s)

Step 3 **REQUIREMENTS**

Refer to the age/grade level requirements for the current school year to determine if this student meets the requirements.

Step 4 **COMPLIANCE DATA**

STUDENT MEETS ALL REQUIREMENTS
Sign at Step 5 and return this form to school.

Or

STUDENT DOES NOT MEET ALL REQUIREMENTS

Check the appropriate box below, sign at Step 5, and return this form to school. PLEASE NOTE THAT INCOMPLETLY IMMUNIZED STUDENTS MAY BE EXCLUDED FROM SCHOOL IF AN OUTBREAK OF ONE OF THESE DISEASES OCCURS.

☐ Although my child has NOT received ALL required doses of vaccine, the FIRST DOSE(S) has/have been received. I understand that the SECOND DOSE(S) must be received by the 90th school day after admission to school this year, and that the THIRD DOSE(S) and FOURTH DOSE(S) if required must be received by the 30th school day next year. I also understand that it is my responsibility to notify the school in writing each time my child receives a dose of required vaccine.

NOTE: Failure to stay on schedule may result in exclusion from school, court action and/or forfeiture penalty.

WAIVERS (List in Step 2 above, the date(s) of any immunizations your child has already received)

☐ **For health reasons** this student should not receive the following immunizations _____

_____ _____
SIGNATURE - Physician Date Signed

☐ **For religious reasons,** I have chosen not to vaccinate this student with the following immunizations (check all that apply)
☐ DTaP/DTP/DT/Td ☐ Tdap, ☐ Polio ☐ Hepatitis B ☐ MMR (Measles, Mumps, Rubella) ☐ Varicella

☐ **For personal conviction reasons,** I have chosen not to vaccinate this student with the following immunizations (check all that apply)
☐ DTaP/DTP/DT/Td ☐ Tdap ☐ Polio ☐ Hepatitis B ☐ MMR (Measles, Mumps, Rubella) ☐ Varicella

Step 5 **SIGNATURE**

This form is complete and accurate to the best of my knowledge. Check one: (I do☐ I do not☐) give permission to share my child's current immunization records and as they are updated in the future with the Wisconsin Immunization Registry (WIR). I understand that I may revoke this consent at any time by sending written notification to the school district. Following the date of revocation, the school district will provide no new records or updates to the WIR.

_____ _____
SIGNATURE - Parent/Guardian/Legal Custodian or Adult Student Date Signed

EMERGENCY CONTACT LIST

CHILD'S NAME: _____ DATE: _____

PLEASE FILL OUT AND SIGN A NEW EMERGENCY CONTACT LIST EACH YEAR

MY NAME: _____ I AM CHILD'S ☐ PARENT ☐ GRANDPARENT ☐ LEGAL GUARDIAN

PLEASE PRINT FULL NAME

CALL ME AT THESE PHONE NUMBERS:

HOME: ☐ N/A NO LANDLINE

MOBILE:

WORK:

IF YOU CAN'T REACH ME, PLEASE CALL:

NAME:

RELATIONSHIP:

HOME: ☐ N/A NO LANDLINE

MOBILE:

WORK:

CHILD'S DOCTOR'S INFORMATION:

NAME:

TEL:

MY CHILD IS CURRENTLY TAKING THESE MEDICATIONS

ALLERGIES:

POTENTIALLY LIFE-THREATENING ☐

By signing this form, I authorize Caregiver to call 911 on behalf of my child in an emergency:

SIGNATURE: _____ DATE: _____

NOTES:

THIS FORM EXPIRES ON:

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education
Bureau of Program Integrity

PROVIDER/PARENT PAYMENT AGREEMENT

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

This Agreement is Between

Business/Provider Name	Parent Name (First, Last)
Tangie's Just Like Mommy CCC	
Provider Number & Location Number	**Second Parent Name (First, Last)**
9000584129 Location 002	
Provider Address	**Provider Phone Number**
1627 south 44th street West Allis, WI 53214	414-384-6655

For the Care of (if more than 3 children complete on separate sheet)

Example

Child Name	**Child Date of Birth**	**Child Care Price**	**Payment Schedule**
Sally Jones	**10/14/2015**	**$150 per week**	**Weekly, on or before** **Payment Due On Fridays**
Child Name (First, Last)	Child Date of Birth	Child Care Price per month, or per week, or other (specify)	Payment Schedule Monthly, on or before 1st (Date of Month), or Weekly, on or before (Day of Week) Other (specify)
Child Name (First, Last)	Child Date of Birth	Child Care Price per month, or per week, or other (specify)	Payment Schedule 1st Monthly, on or before (Date of Month), or Weekly, on or before (Day of Week) other (specify)
Child Name (First, Last)	Child Date of Birth	Child Care Price per month, or per week, or other (specify)	Payment Schedule 1st Monthly, on or before (Date of Month), or Weekly, on or before (Day of Week) other (specify)

This payment does not include extra charges that may be incurred for items including field trips/special events, as agreed upon in advance. Parents are responsible for paying the difference between the subsidy amount and the cost of care.

Parent and Provider Agreed Upon Start Date

Provider's Days and Hours of Operation (as of date)
Monday-Friday 5:30am to 11:00pm

Provider's Policy for Deposits or Holding a Slot
No Refunds for Deposits Payment must be made in full to hold spot.

Provider's Anticipated Closure Dates and Policy for Payment during Closures
Parents are giving annual Calanders for closing dates. No reimbursement for emergencies or weather related closings

Provider's Policy, and Payment Expectations, for Expected Child Absences
Note: Expected absences are those reported in advance by the parent, including vacations or appointments
Children are enrollment base. Payments are to be made reguardless of attendance.

Providers' Policy, and Payment Expectations, for Unexpected Child Absences
Note: Unexpected absences are those not reported in advance, including sick days or no-shows
Children are enrollment base. Payments are to be made reguardless of attendance

Provider's Payment Dispute Policy

Provider's Reasons and Procedures for Termination/Expulsion of a Child(ren)
Provider may terminate for but limited to failure to pay, a disruptive, violent, chronic misbehaving child

Parent's Procedures for Termination/Disenrollment of a Child(ren)
Prior Notification if possibe

Discounts or Scholarships Available to Parents/Children (such as sibling discount, etc.)
NA

Discounts or Scholarships Parents/Children Received and Amount of Discount
NA

Miscellaneous
Examples Include: Child's Anticipated Daily Schedule, Drop-Off and Pick-Up Times, Other Policies
Parents will be charge a separte fee for late pickup and if they go over hours.

By signing this agreement, providers and parents agree to abide by the agreement and written policies of the provider. The provider may amend the policies by giving the parents a copy of the new or changed policy.

Provider Contact Name – (Print)	**Provider Contact Signature**	Date
Litisha Smith		
Parent Name – (Print)	**Parent Signature**	Date

The provider must retain a copy of each current written payment agreement at the location where child care is provided. The provider must retain a copy of an expired written payment agreement for 3 years after the agreement is terminated and the child no longer attends. The expired agreement may be kept at a location where it can be made available to the Department of Children and Families within 24 hours.
DCF-F-5224-E (N. 12/2017)