

The Commonwealth of Massachusetts
Department of Early Education and Care

Child's Enrollment Form

Child Information

Child's Name: _____ Date of Birth: _____

Age at Admission: _____ Date of Admission: _____

Child's Home Address: _____

Home Phone Number: _____

Primary Language: _____ Identifying Marks: _____

Eye Color: _____ Hair Color: _____ Skin Color: _____

Sex: _____ Height: _____ Weight: _____

Parent/Guardian Information

Parent/Guardian Name: _____

Relationship to Child: _____

Home Address: _____

Reachable Phone Number: _____

Email Address: _____

Business Name: _____

Business Address: _____

Business Phone Number: _____

Hours at Work: _____

Parent/Guardian Name: _____

Relationship to Child: _____

Home Address: _____

Reachable Phone Number: _____

Email Address: _____

Business Name: _____

Business Address: _____

Business Phone Number: _____

Hours at Work: _____

•-----•

Additional Information

Child's Physician: _____

Address: _____ Phone Number: _____

Allergies/Special Diets? _____

Individual Health Plan for child with a chronic health condition? If yes, please attach. _____

Copies of any custody agreements, court orders, and restraining orders pertaining to the child?
If yes, please attach. _____

Special limitations or concerns? _____

•-----•

School Age Only

Current School: _____

School Address: _____ School Phone Number: _____

I certify that documentation of physical examination and immunizations in accordance with public school health requirements and lead poisoning screening in accordance with public health requirements are on file at my child's school. **Parent/Guardian initials:**

•-----•

Parent/Guardian Signature

Date

The Lee Youth Association Tuition Payment Policy

Families in the Busy Bee Learning Center (Preschool & Toddler) and the Wake Up and After School Programs will be billed on the third week of each month for the following month. **When signing your child up for a program you are "buying" that slot; therefore you will be charged for all days you are signed up for, regardless of vacations, absences, or snow days.**

Payment is due on the first of the month for the month in advance.

We require credit card or debit card information from all families. This is a requirement of the LYA Board of Directors. If payment is not received on the first, we will automatically charge your credit/debit card on the 10th of the month.

If your account is not paid by the 15th, a 1.25% finance charge will be added to your account per month. Failure to pay in a timely manner may result in termination from our programs.

Acceptable methods of payment are:

1. A credit or debit card payment
2. A bank or money order
3. Payment through PayPal
4. A personal check

Note: If your bank returns a personal check to LYA due to insufficient funds in your account, LYA will no longer accept personal checks for payment and you will be responsible for all bank fees.

Please complete the following:

Name on credit card _____

Credit card/debit card number _____

Expiration date _____

Street address and zip code _____

I have read the above policy and authorize the LYA to charge my credit/debit card on the 10th of the month for the tuition due in that month unless I have already paid by check, bank/money order or PayPal by the first of the month.

Signature _____ Date _____

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION

Regulations for licensed child care facilities require this information to be on file to address the needs of children while in care.

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

Please provide information for Infants and Toddlers (marked *) as appropriate to the age of your child.

DEVELOPMENTAL HISTORY

Age began sitting: _____ crawling: _____ walking: _____ talking: _____

*Does your child pull up? _____ *Crawl? _____ *Walk with support? _____

Any speech difficulties? _____

Special words to describe needs _____

Language spoken at home _____ *Any history of colic? _____

*Does your child use pacifier or suck thumb? _____ *When? _____

*Does your child have a fussy time? _____ *When? _____

*How do you handle this time? _____

HEALTH

Any known complications at birth? _____

Serious illnesses and/or hospitalizations: _____

Special physical conditions, disabilities: _____

Allergies i.e. asthma, hay fever, insect bites, medicine, food reactions: _____

Regular medications: _____

EATING HABITS

Special characteristics or difficulties: _____

*If infant is on a special formula, describe its preparation in detail: _____

Favorite foods: _____

Foods refused: _____

- * Is your child fed held in lap? _____ High chair? _____
- * Does your child eat with spoon? _____ Fork? _____ Hands? _____

TOILET HABITS

- *Are disposable or cloth diapers used? _____ *Is there a frequent occurrence of diaper rash? _____
- *Do you use: oil: _____ powder: _____ lotion: _____ other: _____
- *Are bowel movements regular? _____ How many per day? _____
- *Is there a problem with diarrhea? _____ Constipation? _____
- *Has toilet training been attempted? _____
- *Please describe any particular procedure to be used for your child at the center: _____

- *What is used at home? Pottychair? _____ Special child seat? _____ Regular seat? _____
- *How does your child indicate bathroom needs (include special words): _____
- Is your child ever reluctant to use the bathroom? _____
- Does your child have accidents? _____

SLEEPING HABITS

- *Does your child sleep in a crib? _____ Bed? _____
- Does your child become tired or nap during the day (include when and how long)? _____

Please note: The American Academy of Pediatrics has determined that placing a baby on his/her back to sleep reduces the risk of Sudden Infant Death Syndrome (SIDS). SIDS is the sudden and unexplained death of a baby under one year of age. If your child does not usually sleep on his/her back, please contact your pediatrician immediately to discuss the best sleeping position for your baby. Please also take the time to discuss your child's sleeping position with your caregiver.

- When does your child go to bed at night? _____ and get up in the morning? _____
- Describe any special characteristics or needs (stuffed animal, story, mood on waking etc) _____

SOCIAL RELATIONSHIPS

How would you describe your child? _____

Previous experience with other children/day care: _____

Reaction to strangers: _____ Able to play alone? _____

Favorite toys and activities: _____

Fears (the dark, animals, etc.): _____

How do you comfort your child? _____

What is the method of behavior management/discipline at home? _____

What would you like your child to gain from this childcare experience? _____

DAILY SCHEDULE

Please describe your child's schedule on a typical day. For infants, please include awakening, eating, time out of crib/bed, napping, toilet habits, fussy time, night bedtime, etc. _____

Is there anything else we should know about your child? _____

(Parent/Guardian Signature)

(Date)

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM

Child's Name: _____ Date of Birth: _____

I authorize staff in the child care program who are trained in the basics of first aid/CPR to give my child first aid/CPR when appropriate.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and/or to _____, and to secure necessary medical treatment for my child.

Child's Physician Name: _____
Address: _____
Phone Number: _____

Child's Allergies: _____
Chronic Health Conditions: _____

Emergency Contacts (In order to be contacted)

Name _____
Address _____
Relationship to child _____
Home Phone _____ Cell Phone _____
Do you give permission for child to be released to this person? Yes _____ No _____

Name _____
Address _____
Relationship to child _____
Home Phone _____ Cell Phone _____
Do you give permission for child to be released to this person? Yes _____ No _____

Name _____
Address _____
Relationship to child _____
Home Phone _____ Cell Phone _____
Do you give permission for child to be released to this person? Yes _____ No _____

Health Insurance Coverage _____	Policy # _____
Parent/Guardian Name: _____	Phone _____ Cell _____
Parent/Guardian Name: _____	Phone _____ Cell _____

Parent /Guardian Signature

Date (valid for one year)

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

Small Group and Large Group Transportation Plan and Authorization

CHILD'S NAME: _____

MY CHILD WILL ARRIVE AT THE PROGRAM:

- PARENT DROP OFF
- SUPERVISED WALK
- UNSUPERVISED WALK
- PUBLIC/PRIVATE/VAN
- PROGRAM BUS/VAN
- CONTRACT/VAN
- PRIVATE TRANS. ARRANGED BY PARENT
- OTHER

MY CHILD WILL DEPART FROM THE PROGRAM:

- PARENT PICK UP
- SUPERVISED WALK
- UNSUPERVISED WALK
- PUBLIC/PRIVATE/VAN
- PROGRAM BUS/VAN
- CONTRACT/VAN
- PRIVATE TRANS. ARRANGED BY PARENT
- OTHER

CHILD'S NAME: _____

MY CHILD WILL ARRIVE AT THE PROGRAM:

- PARENT DROP OFF
- SUPERVISED WALK
- UNSUPERVISED WALK
- PUBLIC/PRIVATE/VAN
- PROGRAM BUS/VAN
- CONTRACT/VAN
- PRIVATE TRANS. ARRANGED BY PARENT
- OTHER

MY CHILD WILL DEPART FROM THE PROGRAM:

- PARENT PICK UP
- SUPERVISED WALK
- UNSUPERVISED WALK
- PUBLIC/PRIVATE/VAN
- PROGRAM BUS/VAN
- CONTRACT/VAN
- PRIVATE TRANS. ARRANGED BY PARENT
- OTHER

PARENT /GUARDIAN SIGNATURE _____ DATE _____

REFER TO FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM FOR RELEASE INFORMATION

Demographics Form

We ask Busy Bee Preschool Families to help us gather program demographic Data. We are a United Way funded partner agency and we are required to provide this data to Berkshire United Way. This information is kept in your child's file and is completely confidential. When we report to United Way it is numbers only-no names. Thank you for taking the time to fill this out.

Child's Name

Child's Gender

- Male
- Female
- Transgender
- Unknown Gender

Age Group

- Under 5 Years
- Ages 5-9

Educational Attainment (highest level of education completed in the home)

- Less than 9th grade
- 9th through 12th grade
- High School graduate or GED
- Some college
- Associates Degree
- Bachelor's Degree
- Post graduate Degree

Household Income

- \$0-\$10,000
- \$10,000-\$14,999
- \$15,000-\$24,999
- \$25,000-\$34,999
- \$35,000-\$49,999
- \$50,000-\$74,999
- \$75,000 and over

Geography

Central Berkshire County

- Becket
- Dalton
- Hancock
- Hinsdale
- Lanesborough
- Lee
- Lenox
- New Ashford
- Peru
- Pittsfield
- Richmond
- Savoy
- Washington
- Windsor
- Homeless

South Berkshire County

- Alford
- Egremont
- Great Barrington
- Housatonic
- Monterey
- Mt. Washington
- New Marlborough
- Otis
- Sandisfield
- Sheffield
- Stockbridge
- Tyringham
- West Stockbridge
- Homeless

North Berkshire County

- Adams
- Charlemont
- Cheshire

strengthening families



11. Please tell us about the children living in your household:

Child 1:	Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Birthdate:	/ /
	Your Relationship to Child:	<input type="checkbox"/> Birth Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Other <input type="checkbox"/> Adoptive Parent <input type="checkbox"/> Sibling <input type="checkbox"/> Foster Parent
Child 2:	Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Birthdate:	/ /
	Your Relationship to Child:	<input type="checkbox"/> Birth Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Other <input type="checkbox"/> Adoptive Parent <input type="checkbox"/> Sibling <input type="checkbox"/> Foster Parent
Child 3:	Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Birthdate:	/ /
	Your Relationship to Child:	<input type="checkbox"/> Birth Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Other <input type="checkbox"/> Adoptive Parent <input type="checkbox"/> Sibling <input type="checkbox"/> Foster Parent
Child 4:	Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Birthdate:	/ /
	Your Relationship to Child:	<input type="checkbox"/> Birth Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Other <input type="checkbox"/> Adoptive Parent <input type="checkbox"/> Sibling <input type="checkbox"/> Foster Parent

If there are more than four children living in the household, please use the blank space on the back of this page.

strengthening families



Part One: Please CIRCLE the number that describes how often the statements are true for you or your family. The numbers represent a scale from 1 to 7 where each of the numbers represents a different amount of time.

	Never	Very Rarely	Rarely	About Half the Time	Frequently	Very Frequently	Always
1. In my family, we talk about problems.	1	2	3	4	5	6	7
2. When we argue, my family listens to "both sides of the story."	1	2	3	4	5	6	7
3. In my family, we take time to listen to each other.	1	2	3	4	5	6	7
4. My family pulls together when things are stressful.	1	2	3	4	5	6	7
5. My family is able to solve our problems.	1	2	3	4	5	6	7

Part Two: Please CIRCLE the number that best describes how much you agree or disagree with the statement.

	Strongly Disagree	Mostly Disagree	Slightly Disagree	Neutral	Slightly Agree	Mostly Agree	Agree
6. I have others who will listen when I need to talk about my problems.	1	2	3	4	5	6	7
7. When I am lonely, there are several people I can talk to.	1	2	3	4	5	6	7
8. I would have no idea where to turn if my family needed food or housing.	1	2	3	4	5	6	7
9. I wouldn't know where to go for help if I had trouble making ends meet.	1	2	3	4	5	6	7
10. If there is a crisis, I have others I can talk to.	1	2	3	4	5	6	7
11. If I needed help finding a job, I wouldn't know where to go for help.	1	2	3	4	5	6	7

Busy Bee Learning Center at the Lee Youth Association

Authorization for release of information

I hereby authorize: _____
Name of Agency

To exchange information with the Busy Bee Learning Center Staff regarding:

Name of Child

Date of Birth

Signature of legal guardian or parent

Date:

Name: _____
Please print

Relationship: _____

Child's Photo

Individual Health Care Plan Form

Plan must be renewed annually or when child's condition changes

Check all that apply....

Plan was created by:

- Parent
- Doctor or Licensed Practitioner
- Program's Health Care Consultant
- Older school age child (9+ yrs. of age)
- Other: _____

Plan is maintained by:

- Director
- Assistant Director
- Child's Educator
- Other: _____

Name of child:	Date:
Any change to the child's Health Care Plan? <input type="checkbox"/> YES (indicate changes below) <input type="checkbox"/> NO (updated physician/parental signatures required)	
Name of chronic health care condition:	
Description of chronic health care condition:	
Symptoms:	
Medical treatment necessary while at the program:	
Potential side effects of treatment:	
Potential consequences if treatment is not administered:	
Name of educators that received training addressing the medical condition:	
Person who trained the educator (child's Health Care Practitioner, child's parent, program's Health Care Consultant):	

Name of Licensed Health Care Practitioner (please print): _____

Licensed Health Care Practitioner authorization: _____ Date: _____

Parental/Guardian consent: _____ Date: _____

For Older Children ONLY (9+ years of age)

With written parental consent and authorization of a licensed health care practitioner, this Individual Health Care Plan permits older school age children to carry their own inhaler and/or epinephrine auto-injector and use them as needed without the direct supervision of an educator.

The educator is aware of the contents and requirements of the child's Individual Health Care Plan specifying how the inhaler or epinephrine auto-injector will be kept secure from access by other children in the program. Whenever an Individual Health Care Plan provides for a child to carry his or her own medication, the licensee must maintain on-site a back-up supply of the medication for use as needed.

Age of child	Date of birth	Back-up medication received? YES NO
Parent signature		Date
Administrator's signature		Date

Busy Bee Learning Center at The Lee Youth Association

Authorization for release of Medical Information

Your child's medical records cannot be released to us until this form is completed in its entirety and returned to the office

Patient's Name _____

DOB _____

Parent or Guardian's Name _____

I authorize _____ to release the following information to Busy Bee Learning Center

Dates of most recent physical exam, immunization records, and health records related to my child's attendance in care, including any medical conditions, symptoms, and treatments.

I understand this authorization may be revoked at any time by writing to the person or entity authorized to release my child's information, except to the extent that disclosure made in good faith has already in reliance on this authorization. This authorization expires upon termination from the program.

Signature _____

Date _____

Busy Bee Learning Center at the Lee Youth Association

Blanket Policy Topical Ointment

I hereby authorize the Busy Bee Staff to administer the following non-prescription ointments to my child.

<u>Medication</u>	<u>When</u>	<u>Child will apply (x)</u>
Sunscreen, Insect Repellent	As needed	
Topical Ointment (Vaseline, Lotions, Neosporin, Hand Sanitizer)	As needed	

Prescription medication(s) may be given by order of physician only. Order must include; dosage, times given and number of days required.

*Prescriptions must be in an original container

*Parent/Guardian must sign a separate consent form

Some nonprescription medication(s) such as Tylenol or Cough Syrup may be given when a written permission from the parent/guardian detailing dosage and times given is submitted.

*After ten days, a new permission slip is required for non-prescription medication.

Busy Bee Learning Center is required to log all medication that is administered. The log must include dosage, and time(s) medication is taken. (Parents may request a copy)

Parent/Guardian Signature

Date

Busy Bee Learning Center at the Lee Youth Association

Authorization Form

These authorizations are designed for the protection and security of your child and the Center. Please check the appropriate line for each section.

Field trips:

I give my child _____ permission to attend all field trips off the Busy Bee Learning Center grounds throughout the year, including all walking trips through the town of Lee.

I do not give my child _____ permission to attend all field trips off the Busy Bee Learning Center grounds throughout the year, including all walking trips through the town of Lee.

First Aid:

I give The Busy Bee Learning Center personnel permission to administer first aid and/or cpr to my child.

I do not give The Busy Bee Learning Center personnel permission to administer first aid and/or cpr to my child.

Photographs/Videos:

I give permission for my child to be photographed/ and or video taped in Center activities and those photographs/videos may be used for publicity for the center, the center's website, and the classrooms website on facebook.

I do not give permission for my child to be photographed/ and or video taped in Center activities and those photographs/ videos may be used for publicity for the center.

Lee Elementary School:

I give permission for my child's final progress report to be given to the kindergarten teachers

I give permission for the preschool director to attend the kindergarten placement meeting at Lee Elm. School and to discuss my child

I do not give permission for my child's final progress report to be given to the kindergarten teachers

I do not give permission for the preschool director to attend the kindergarten placement meeting at Lee Elm. School to discuss my child

I understand the above statements.

Parent or Guardian Signature:

Date:

Busy Bee Preschool Staff Signature:

Date:

*Busy Bee Learning Center
At the Lee Youth Association*

Enrollment Agreement:

I hereby apply for admission of _____ to the Busy Bee Preschool and agree to the following rules and regulations:

1. I agree to pay my weekly fee on a continuous basis.
2. I understand that the full fee is expected in spite of absences because you are securing the slot for your child to attend the preschool.
3. I understand that if I am only signing my child up for part time care, priorities for the preschool are given to full time children. This means as a part time parent, you can have the slot until a full timer comes along. At this point; you have the choice of taking the full time slot or the preschool will give you a two week notice of termination.
4. Failure to adhere to the agreed upon payment schedule will results in a ten day notice, then termination of care. Extenuating circumstances should be discussed with the director or the accounting department in order to arrange a payment plan.
5. I agree to give two weeks notice of pending termination. Failure to give such notice will result in an assessment of full fee charges for two weeks after termination.
6. I agree to provide a signed copy of my child's pediatrician's Universal Health Form, or equivalent, which verifies my child has been examined one year from enrollment, that any known special considerations are under appropriate treatment and indicating all allergies or other conditions that would require special care before enrollment. Annually thereafter, I agree to provide an updated record of my child's immunizations according to the Department of Public Health schedule.
7. I agree to present a doctor's certificate if my child is absent because of a contagious disease or other illness or injury, if such is requested.
8. I agree to call for my child as soon as possible in care of injury or illness.
9. I will accept the expense of emergency medical aid should the need arise.
10. I agree to notify Busy Bee Preschool staff if my child cannot be picked up at the prearranged time. I understand that there is a Late Pick-up policy. There is a \$5.00 per a minute late will be charged to parent(s). Following a period of 15 minutes, we will contact persons who have been designated by the parents as "emergency contact people." After 30 minutes, and we are unable to reach anyone then we will contact the Department of Children and Families to file a report of Abuse and/or neglect (a 51A), and the local police department.
11. I agree to bring my child to the Busy Bee Preschool by: _____ and pick him/her up by: _____.
12. I understand that my child will only be released to me or the persons I have authorized. Any changes in these arrangements must be made in advance to the director of the Busy Bee Preschool.
13. I agree to supply a copy of any restraining, court or visitation orders pertaining to my child.
14. I agree to notify the Busy Bee Preschool if my child will be late or absent.
15. I will be willing to share and discuss any problems arising at home or in the Busy Bee Preschool in regard to my child through a scheduled conference.

Parent/Guardian Signature: _____ Date: _____

Director Signature: _____ Date: _____

Children's Schedule

Please sign and return

Child's Name: _____

Date of Birth: _____

Days	Arrival Time	Departure Time
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

In order to meet the needs of families and children for access of quality child cares, it is necessary to make the best possible use of child care resources. The Busy Bee Learning Center is required to make every effort to ensure that each child care slot is filled at all times. Whenever a child leaves care, The Busy Bee Staff must move quickly to make that slot available to another child who is waiting for care. Also it is important to adhere to the arrival and departure times for your child to assure that we have the appropriate amount of staff caring for the children.

In order be sure that our records are accurate for licensing, we ask that you do the following three things.

- 1.) Notify Lindsay at least 2 weeks in advance if you plan to remove your child from care.
- 2.) Notify your child's teacher immediately to explain any absences of your child.
- 3.) Notify Lindsay at least two weeks in advance if you would like to switch days.

My signature below indicates that I understand the information in this document and agree to notify the Busy Bee Learning Center as indicated above.

Signature of Parent or Guardian

Date

March 8, 2019

Dear LYA and Busy Bee Families:

The state of Massachusetts funds a subsidy program through New England Farmworker's Council (NEF). The name is a little bit misleading but to clarify they are, simply put, the organization that manages this state subsidy program.

We would like to provide you with the necessary information so that you may review this and decide if you are eligible to receive funding. There is a waiting list but if you are eligible, you should complete the attached form, mail it to the address at the bottom of the page and get on the waiting list. The local contact information if you would like to call with questions is: 413-236-5890. There are two people who work in the Pittsfield office – Mable and Jean. They are very informative and easy to work with.

You would need to meet the income and service need requirements as listed below:

Income Requirement

To meet the income requirement, your household income must initially be at or below 50% of the state median income (SMI) – please see the attached chart. If you or your child has a documented disability or special need, your household income must initially be at or below 85% of the SMI. Use the SMI Income Eligibility chart to see if your household income is within limits.

Service Need (Activity) Requirement

To meet the service need/activity requirement for child care financial assistance, all of the adult members in your household must be:

- Working, seeking employment, or enrolled in an education or training program (not including graduate, law, or medical school) for at least 20 hours per week for part-time care, and at least 30 hours per week for full-time care;
- Retired and older than 65; or
- You have a diagnosed and documented disability or special need.*

*Disability/special need of parent is limited to two years.

Please feel free to contact Kathy or Sharon at the LYA with questions - 413-243-5535

Date: _____
PLEASE PRINT CLEARLY

NEFWC Waitlist Initial Intake Form

Entered By: _____
Date Completed: _____

Parent Name: _____ Parent Soc. Security #: _____ DOB: _____ Gender: _____

- Single Parent Married Teen Parent
- Foster Parent Guardian Military Parent
- Grandparent Under 65 Grandparent 65 or Over

- Race: Asian Black/African American Caucasian Hispanic
 American Indian/Alaskan Native Native Hawaiian/Other Pacific
 Other

Parent Name: _____ Parent Soc. Security #: _____ DOB: _____ Gender: _____

- Single Parent Married Teen Parent
- Foster Parent Guardian Military Parent
- Grandparent Under 65 Grandparent 65 or Over

- Race: Asian Black/African American Caucasian Hispanic
 American Indian/Alaskan Native Native Hawaiian/Other Pacific
 Other

Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Other Phone Number: _____

Primary Language: _____ Secondary Language: _____

Household Monthly Income: _____ Total Family Size: _____

- Income Details:
- Employment Self-Employment
 - Food Stamps Child Support
 - Child Support Housing
 - SSA/SSI Other Fed Benefit

Reason for Needing Child Care: (please check all that apply)

- Employment Education & Training Seeking Employment Special Need of Child
- Special Need of Parent TAFDC Recipient/Household Receiving Services from DCF Homeless Shelter Activity
- Retired Caregiver Age 65 & Over

Children: PLEASE PRINT CLEARLY

First Name	Middle Name	Last Name	DOB	Soc. Sec. Number	Gender
Child Has Special Needs (y/n) _____		Race: <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaskan Native			
School Grade Level _____		<input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian/Other Pacific <input type="checkbox"/> Other			

First Name	Middle Name	Last Name	DOB	Soc. Sec. Number	Gender
Child Has Special Needs (y/n) _____		Race: <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaskan Native			
School Grade Level _____		<input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian/Other Pacific <input type="checkbox"/> Other			

First Name	Middle Name	Last Name	DOB	Soc. Sec. Number	Gender
Child Has Special Needs (y/n) _____		Race: <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaskan Native			
School Grade Level _____		<input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian/Other Pacific <input type="checkbox"/> Other			

Child Care Waitlist Priority Codes: Please check all that apply

- General Priority Child of Foster Care Child of Homeless Family Child of Military Personnel
- Child of Teen Parent Child with Special Needs Parent with Special Needs Cont. of Care-Aging Out
- Cont. of Care-Approved Break in Service Cont. of Care-ARRA Cont. of Care-Geographic Relocation
- Cont. of Care-Homeless Contract Cont. of Care-Prior Year Summer Only
- Cont. of Care-Supportive Referral Cont. of Care-Teen Parent Contract
- Grandparent/Guardian Sibling Contract Sibling Voucher Summer Only Care

Please Return Completed Form to:

New England Farm Workers' Council
41 North St. Suite 106 Pittsfield, MA 01201 or Fax to (413) 236-5894