Are you looking for childcare this summer?

Highland County Community Action Organization (HCCAO) in Hillsboro and Greenfield is offering childcare for infants, toddlers, preschoolers, and school-agers!
This is open to all of the community!

- Open from 6:00am to 6:00pm
  - Full Time (25-60 hours/week)
  - Part Time (7-25 hours/week)
  - Hourly (under 7 hours/week)
- Operating May 31-September 2 (Closed July 4-Holiday)
- Highly Qualified and Experienced Staff
- Creative and Educational Activities
- Licensed and Certified
- Limited spots available so secure your spot now!
- $25 registration fee
- Call Valerie Williams (937-393-3458) or stop by one of our locations to fill out a short application packet.

Highland County Community Action Partnership

	Full Time Rate	Part Time Rate	Hourly Rate
Infant (under age 1)	$171.19	$116.49	$8.12
Toddler	$156.53	$98.22	$6.13
Preschool (age 3-5)	$136.83	$72.84	$4.50
School-age (Kindergarten eligible-less than 15)	$124.92	$87.10	$5.63

HCCAO Child Care Payment Information:

Tuition Fees and Payment Policies:

Full Time= 25-60 hours a week
Part Time= 7-25 hours a week
Hourly= Less than 7 hours a week

The weekly payment fee covers a slot, which allows the child to attend any day, Monday through Friday 6am to 6pm. **All payments are due on Mondays of the current week.**

	Full Time Rate	Part Time Rate	Hourly Rate
Infant (under age 1)	$171.19	$116.49	$8.12
Toddler	$156.53	$98.22	$6.13
Preschool (age 3-5)	$136.83	$72.84	$4.50
School-age (Kind. eligible-less than 15)	$124.92	$87.10	$5.63

Private Pay or if you have a co-pay - In the event of illness, full payment is expected, except for an extended illness. An extended illness that keeps the child out of the center for more than 5 consecutive weekdays. Half payment is required for extended illnesses to maintain the child's space. If your child is absent due to illness, please contact the Center. Also, a doctor's note will be required for child to return to school.

All checks are to be made payable to: Highland County Community Action Organization. Tuition should be placed in the mailbox in the entry area. If paying by cash, tuition is to be paid at HCCAO to Jennifer Baker or Beth Allering. When paying by money order or check – pay at HCCAO. **PLEASE WRITE YOUR CHILD'S NAME ON THE CHECK AND ENSURE THAT YOUR SIGNATURE IS LEGIBLE.** Our tax ID number is available upon request.

Vacations: Each child is granted five (5) days vacation in a calendar year. **With a two-week notification** the rate will be half of the regular rate. An absence/vacation form is also to be completed when giving the two weeks notification. *(form is the last page of handbook).* This form is to be returned to the Center. This will ensure your child's space is secure while they are out on these days. If center is not notified two weeks in advance the regular rate will be due. If a child is on vacation more than five (5) days, the normal rate will be charged after the first week.

Delinquent Accounts/Returned Checks: A fee of $25 per week will be charged to the account if payment is not received by each Monday of the current week. A $35.00 fee will be charged for any returned checks due to insufficient funds and the parent will be required to pay in cash until all account balances are settled, cash payments can only be made at Highland County Community Action Organization. After two weeks of non-payment you will receive a notice of your balance and requesting you to settle your account. Arrangements must be made with the Center immediately. If the account remains unpaid your child will not be permitted to attend class until your account is settled. If you do not pay your balance by the fourth week, your account will be turned over for collection.

Late Pick-Up Charges: If a parent realizes that circumstances beyond their control are going to delay a pick-up, a phone call is required. A late fee of $1.00 per minute per child will be charged after 6:00pm. Please remember our staff is anxious to get home on time to their families and commitments.

ODJFS PFCC families must TAP the childcare information in the IPAD during drop off and pick up. When parent/guardian is not available to swipe due to someone else dropping off or picking up, they are required to swipe within 24 hours. If TAP is not done properly, parents must back TAP *(see staff for assistance)* Also, if a parent does not pay their co-pay a claim may be filed with ODJFS which may lead to possible loss of benefits. If a child is not fulfilling allotted weekly hours, parents will have an additional fee.

Highland County Community Action Partnership

Child's Name: _____

Child's Date of Birth: _____

Address: _____

Phone Number: _____

Summer Child Care Schedule:

___Monday Drop Off Time: _____ Pick Up Time: _____

___Tuesday Drop Off Time: _____ Pick Up Time: _____

___Wednesday Drop Off Time: _____ Pick Up Time: _____

___Thursday Drop Off Time: _____ Pick Up Time: _____

___Friday Drop Off Time: _____ Pick Up Time: _____

____ Hourly Rate

____ Part Time Rate

____ Full Time Rate

Received Date: _____ (Office Use)

Approved Date: _____

Private Pay _____

PFCC _____

Hourly _____

Part Time _____

Full Time _____

Greenfield _____

Hillsboro _____

Infant Room _____

Toddler Room _____

Preschool Room _____

School-age Room _____

RELEASE FORM FOR HCCAO CHILD CARE

Child's First Name: _____ Middle Name: _____ Last Name: _____

Parents' /Guardians' Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Home Address: _____

EMERGENCY CONTACTS:

Please note that these contacts may be called and do have permission for your child to be released to, if you can not be reached. ***(Contacts will be called in order that they are listed.)***

1. Name: _____ ***Address:*** _____
Relationship to child: _____ ***Phone #:*** _____
Date name added: _____ ***Initials:*** _____

2. Name: _____ ***Address:*** _____
Relationship to child: _____ ***Phone #:*** _____
Date name added: _____ ***Initials:*** _____

3. Name: _____ ***Address:*** _____
Relationship to child: _____ ***Phone # :*** _____
Date name added: _____ ***Initials:*** _____

4. Name: _____ ***Address:*** _____
Relationship to child: _____ ***Phone #:*** _____
Date name added: _____ ***Initials:*** _____

5. Name: _____ ***Address:*** _____
Relationship to child: _____ ***Phone # :*** _____
Date name added: _____ ***Initials:*** _____

6. Name : _____ ***Address :*** _____
Relationship to child: _____ ***Phone #:*** _____
Date name added: _____ ***Initials:*** _____

PARENT'S SIGNATURE _____ **DATE:** _____

Ohio Department of Job and Family Services

CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name	Date of Birth	First Day at Program/Home
Home Address		City
State	Zip Code	Home Telephone Number

Parent/Guardian Name #1	Relationship to Child
Home Address ☐ Same as Child's	Home Telephone Number ☐ Same as Child's
City	State / Zip
Email Address *(if applicable)*	Cell Phone *(if applicable)*
Parent's Work/School Name	Parent's Work/School Telephone Number
Parent's Work/School Address	City

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Parent/Guardian Name #2	Relationship to Child
Home Address ☐ Same as Child's	Home Telephone Number ☐ Same as Child's
City	State / Zip
Email Address *(if applicable)*	Cell Phone
Parent's Work/School Name	Parent's Work/School Telephone Number
Parent's Work/School Address	City

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Emergency Contacts: Parents **cannot be listed** as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness **if you cannot be reached.** Any person listed should be able to assist in contacting you. At least one person listed must be able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

Name	Name
City / State	City / State
Telephone Number / Relationship to Child	Telephone Number / Relationship to Child
Other numbers where emergency contact can be reached *(if applicable)*	Other numbers where emergency contact can be reached *(if applicable)*

Name of Physician or Clinic/Hospital	
Street Address	
City / State	Telephone Number

Child's Name

Allergies, Special Health or Medical Conditions, and Medical Foods

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

☐ No

☐ Yes - *check all that apply* ☐ Food ☐ Medication ☐ Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms to take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Does your child have a developmental delay or special health or medical condition? (*check one*)

☐ No

☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Is your child currently using any medication or medical food? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication or medical food need to be administered at the child care program/home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

☐ No

☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

☐ No

☐ Yes - written instructions from the child's health care provider must be on file.

☐ N/A - program does not provide meals or snacks to the child.

Child's Name

List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff **or medical personnel** in an emergency situation.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

☐ Not applicable

Child's Name

Diapering Statement

Is your child toilet trained? ☐ Yes *(If yes, skip to Emergency Transportation Authorization section)*
☐ No (If no, fill out the following:)

The program's policy is to check diapers every _____ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

Give *Permission* to Transport			**Do Not Give *Permission* to Transport**	
Program or Home Name HCCAO HS IEHS		**OR**	Program or Home Name	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.		**Do not sign both**	**does not have permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:	
Parent's Signature	Date		Parent's Signature	Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. ☐ Yes ☐ No *(check one)*

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note:
This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15, 5101:2-13-15, and 5101:2-14-04. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

Client Number:	Agency:	Application Date:
	Highland County Community Action Org. Inc.	

Primary Applicant First Name	M.I.	Last Name

Social Security Number	Date of Birth	Gender
___/__/____	__/__/____	☐ Female ☐ Other ☐ Male

Household Information:

Household Size:	Family Type	Building Type
	☐ Single Parent/Female	☐ Mobile Home
Housing Status	☐ Single Parent/Male	☐ Single Family
☐ Own	☐ Two-Parent Household	☐ Multi-family low rise (3 stories or less)
☐ Rent	☐ Single Person	☐ Multi-family high rise (3 stories or more)
☐ Other Permanent Housing	☐ Two Adults/No Children	
☐ Homeless	☐ Non-related Adults with children	
☐ Other	☐ Multigenerational Household	
	☐ Other	

Customer Address:

Current Service Address:		Apartment/Lot/Unit Floor:	
Current Mailing Address (if different from above):		Apartment/Lot/Unit Floor:	
City:	State:	Zip Code:	County:
Phone Number:		Email Address:	
Preferred method of contact?			

Primary Applicant Demographic Information:

Ethnicity	Race	Education
☐ Hispanic, Latino or Spanish Origins	☐ American Indian/Alaskan Native	☐ Grade 0-8
☐ Not Hispanic, Latino or Spanish Origins	☐ Asian	☐ Grades 9-12/Non-Graduate
	☐ Black/African American	☐ High School Grad/GED
	☐ Native Hawaiian/Other Pacific Islander	☐ 12+ Some Post-Secondary Education
	☐ Other	☐ 2 or 4 Year College Graduate
	☐ Unknown/Not-reported	☐ Graduate or other post-secondary school
	☐ White	
Client Disabled?	**Military Status**	**Is Client a US Citizen?**
☐ Yes	☐ Veteran	☐ Yes
	☐ Active Military	
Work Status	**Health Insurance Type**	**Non-Cash Benefits**
☐ Employed full-time	☐ Medicaid	☐ Affordable Care Act Subsidy
☐ Employed part-time	☐ Medicare	☐ Childcare Voucher
☐ Migrant Seasonal Farm Worker	☐ Private/Employment Based	☐ Housing Choice Voucher
☐ Unemployed (short-term, 6 months or less)	☐ Self-Insured/Direct Pay	☐ HUD-VASH
☐ Unemployed (long-term, more than 6 months)	☐ None	☐ Other
☐ Unemployed (not in labor force)	☐ State Children's Health Insurance Program	☐ Permanent Supportive Housing
☐ Retired	☐ State Health Insurance for Adults	☐ Public Housing
☐ Unknown/not reported		☐ SNAP
☐ Youth ages 14-24 who are neither working nor in school		☐ WIC

Additional Household Members:

First Name	M.I.	Last Name
Social Security Number	**Date of Birth**	**Gender**
___/__/____	__/__/____	☐ Female ☐ Other ☐ Male
Ethnicity	**Race**	**Education**
☐ Hispanic, Latino or Spanish Origins ☐ Not Hispanic, Latino or Spanish Origins	☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Unknown/Not-reported ☐ White	☐ Grade 0-8 ☐ Grades 9-12/Non-Graduate ☐ High School Grad/GED ☐ 12+ Some Post-Secondary ☐ Education ☐ 2 or 4 Year College Graduate ☐ Graduate or other post-secondary school
Client Disabled?	**Military Status**	**Is Client a US Citizen?**
☐ Yes	☐ Veteran ☐ Active Military	☐ Yes
Work Status	**Health Insurance Type**	**Non-Cash Benefits**
☐ Employed full-time ☐ Employed part-time ☐ Migrant Seasonal Farm Worker ☐ Unemployed (short-term, 6 months or less) ☐ Unemployed (long-term, more than 6 months) ☐ Unemployed (not in labor force) ☐ Retired ☐ Unknown/not reported ☐ Youth ages 14-24 who are neither working nor in school	☐ Medicaid ☐ Medicare ☐ Private/Employment Based ☐ Self-Insured/Direct Pay ☐ None ☐ State Children's Health Insurance Program ☐ State Health Insurance for Adults	☐ Affordable Care Act Subsidy ☐ Childcare Voucher ☐ Housing Choice Voucher ☐ HUD-VASH ☐ Other ☐ Permanent Supportive Housing ☐ Public Housing ☐ SNAP ☐ WIC

First Name	M.I.	Last Name
Social Security Number	**Date of Birth**	**Gender**
___/__/____	__/__/____	☐ Female ☐ Other ☐ Male
Ethnicity	**Race**	**Education**
☐ Hispanic, Latino or Spanish Origins ☐ Not Hispanic, Latino or Spanish Origins	☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Unknown/Not-reported ☐ White	☐ Grade 0-8 ☐ Grades 9-12/Non-Graduate ☐ High School Grad/GED ☐ 12+ Some Post-Secondary ☐ Education ☐ 2 or 4 Year College Graduate ☐ Graduate or other post-secondary school
Client Disabled?	**Military Status**	**Is Client a US Citizen?**
☐ Yes	☐ Veteran ☐ Active Military	☐ Yes
Work Status	**Health Insurance Type**	**Non-Cash Benefits**
☐ Employed full-time ☐ Employed part-time ☐ Migrant Seasonal Farm Worker ☐ Unemployed (short-term, 6 months or less) ☐ Unemployed (long-term, more than 6 months) ☐ Unemployed (not in labor force) ☐ Retired ☐ Unknown/not reported ☐ Youth ages 14-24 who are neither working nor in school	☐ Medicaid ☐ Medicare ☐ Private/Employment Based ☐ Self-Insured/Direct Pay ☐ None ☐ State Children's Health Insurance Program ☐ State Health Insurance for Adults	☐ Affordable Care Act Subsidy ☐ Childcare Voucher ☐ Housing Choice Voucher ☐ HUD-VASH ☐ Other ☐ Permanent Supportive Housing ☐ Public Housing ☐ SNAP ☐ WIC

Countable Income Information		
Customer Name:	Total Amount Received	Period Received (30, 90 or 365 days)
	$	
	$	
	$	
	$	
	$	
	$	
	$	

Income Category:		Frequency:	Total Amount:
☐ Fixed	☐ SSI ☐ SSDI ☐ SSA ☐ Pension ☐ Window/Widower's benefit ☐ Adoption Assistance ☐ Alimony ☐ Black Lung pension	☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Yearly	$ _____
☐ Earned	☐ Wages ☐ Self-employment ☐ Active Military Pay ☐ Ohio Electronic Child care	☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Yearly	$ _____
☐ Supplemental	☐ Unemployment ☐ Utility Assistance ☐ Workers' Compensation ☐ Ohio Works First (TANF, ADC)	☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Yearly	$ _____
☐ Other	☐ Cash withdraws from: IRA, Annuities, Other investments ☐ Lump sum payout from: SSI, SSDI, Estate & Trust settlements, Divorce settlements, insurance payout, lotter winnings ☐ Interest Income	☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Yearly	$ _____
☐ None			$ _____
		Total:	$ _____

Deductions:		
Deductible Income:	Frequency:	Total Amount:
☐ Health Insurance Premiums ☐ Health Care Spending Accounts ☐ Medicaid Spend Down (deductibles) ☐ Medicare Part D (RX premium) ☐ Child Support paid-out ☐ Attorney fees for estate or trust settlements	☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Yearly	$ _____
Total Household Income (Countable Income – Deductions)		$ _____
Federal Poverty Level:		_____ %

I certify that this statement is true and correct to the best of my knowledge, and I authorize the release of any or all information necessary for verification purposes.

Applicant Signature: _____ Date: _____

Approved by: _____ Date: _____

Excluded Income		
Excluded Income:	Frequency:	Total Amount:
☐ Agency Orange Pension ☐ Veterans affairs, service related disability ☐ Handicapped income (i.e. work programs for the blind or disabled) ☐ Title V wages (i.e. senior employment programs) ☐ Volunteers in Service to America Stipend (VISTA) ☐ Work allowances (work requirement to receive OWF assistance) ☐ Income earned by dependent minors ☐ Tax refunds/rebates ☐ Education assistance (grants stipends for tuition/books) ☐ Stipends for foster care ☐ Military allowances for subsistence ☐ Ohio waiver program (Medicaid benefit for caregiver) ☐ Prevention retention and contingency (i.e. emergency services, rental asst.) ☐ transportation allowances (WIOA) ☐ Proceeds from reverse mortgage ☐ FEMA, cash payments ☐ Title III Disaster relief emergency assistance	☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Yearly	$ _____

Expenses:	
Expense Type:	Total Monthly Expense amount:
Food	$ _____
Shelter	$ _____
Child Care	$ _____
Transportation	$ _____
Utilities	$ _____
Total:	$ _____