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Authorized Persons Form

Client Name: _____

Client DOB: _____

Client Information:

Child's Name:_____ Date of Birth:_____

Child's Current Address:_____

City:_____ State: _____ Zip: _____

Does the Child reside with legal guardian: ☐ YES ☐ NO

1. Parent/Legal Guardian Printed Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail Address: _____

Name & Address of Employment/School:_____

2. Parent/Legal Guardian Printed Name: _____

Address: (if different from above) _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail Address: _____

Name & Address of Employment/School:_____

Authorized Contact:

I, _____ hereby consent to the following people having contact with my child while attending CRCC. List their names and their relationship to your child.

1. Name: _____ Relationship to the child: _____
2. Name: _____ Relationship to the child: _____
3. Name: _____ Relationship to the child: _____

Parent/Legal Guardian Signature: _____ Date: _____

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Client Name: _____

Client DOB: _____

Authorized Pick-up Persons/Emergency Contacts:

1st Pick-Up Name: _____ Phone #:_____

Relationship to the child: _____

2nd Pick-Up Name: _____ Phone #:_____

Relationship to the child: _____

3rd Pick-Up Name: _____ Phone #:_____

Relationship to the child: _____

Additional Authorized Contact:

1. Social Worker: _____Phone #: _____
2. Visitation Specialist: _____ Phone #: _____
3. Foster Care Specialist: _____Phone #: _____
4. Family Support Specialist: _____ Phone #: _____

Restricted Persons:

1. Name:_____ Relationship to Child: _____
2. Name:_____ Relationship to Child: _____

Parent/Legal Guardian Signature: _____ Date: _____

Children's Respite Care Center
Unencrypted Email Consent Form

As a parent or an authorized representative of a child receiving services through Children's Respite Care Center ("CRCC") you may request that we communicate with you about your child through unencrypted email ("Messages"). Due to the nature of our services, these Messages may contain protected health information. Because CRCC is committed to protecting the privacy of your child's PHI, **we want you to be aware of the risks of sending and receiving Messages and protected health information using unencrypted email.** These risks include, but are not limited to, the following:

- A majority of the popular email services (e.g., Gmail, iCloud, Yahoo, Microsoft 365) do not utilize encrypted email by default.
- There is a chance that unencrypted emails may be intercepted in-transit by an unauthorized third party. Once intercepted, the unauthorized third party may be able to access the information and contents of an email because it was sent through unencrypted email.
- CRCC's security procedures, programs, and hardware cannot protect personal health information once a Message leaves CRCC's email servers.
- Backup copies of emails may still exist even after the sender or receiver deleted the emails.

Acknowledgment and Agreement

By signing this form and providing CRCC with the email address below, I acknowledge that I have read and fully understand the risks associated with using unencrypted email to send and receive Messages that may contain protected health information between CRCC and me. I understand and agree that CRCC cannot guarantee the security and confidentiality of any Message and protected health information sent through unencrypted email. I also understand that if the email address I provide is a shared email address (for example, if I share the same email address with a spouse or other family member), or if others have access to my email account, these individuals may be able to see the Messages. I understand that I may revoke my consent at any time by notifying CRCC in writing and that my consent is valid until I revoke it.

I understand the risks of using unencrypted email and do hereby request and consent to CRCC sending me protected health information through unencrypted email regarding my child(ren).

Email address:_____; Date:_____

Signature:_____; Name:_____

Client Name: _____

Client DOB: _____

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Consent to Treat and Services Agreement

Initial at each line to acknowledge your understanding of the following clauses:

_____ **(Initial if applicable) Weekend Respite Care Services:** I agree CRCC will provide Weekend Respite Services at the CRCC Northwest location, 2010 N. 88th Street.

_____ **Student Instruction:** I understand that CRCC provides instruction to students and while at CRCC my child could be treated and/or observed by a supervised clinical or education student or intern.

_____ **Exposure to Client Blood or Body Fluid:** Parents/Legal Guardians will agree to disclose all known exposure to or confirmed presence of any communicable diseases that the client has contracted and work with CRCC to help decrease medical testing should they be accidentally exposed to client's blood or body fluids (i.e. via accidental needle stick, human bite breaking the skin, etc.)

_____ **Abuse & Neglect Reporting:** CRCC is obligated by state law as mandatory abuse and neglect reporters and will report any suspected abuse or neglect to the Department of Health and Human Services.

_____ **Emergency Treatment:** I acknowledge my child may have unique heath care needs in the case of an emergency. I will provide any information or supplies necessary to use in the event of an emergency prior to my child admission, update this information as needed and review the emergency plan in my child's Plan of Care with CRCC. I authorize CRCC to consent for any emergency treatment that may be advised by a licensed physician and any specialty consultants that are deemed necessary for treatment of my child to include but not limited to: transportation, medical examination and testing, and hospitalization. I understand that I am financially responsible for any treatment and/or services rendered.

_____ **Authorized Release of Child:** Parent/Legal Guardian agree to provide a minimum of one emergency contact's name and active phone number, who is able to be contacted and has the parent/legal guardian's permission to remove client from CRCC's physical custody in the event that CRCC has been unsuccessful in contacting the parent/legal guardian for any reason. I authorize CRCC to both receive and provide basic private health information as needed to/from the client's emergency contacts. I acknowledge that I may change my child's emergency contacts at any time and that I may request a list of who CRCC has listed as my emergency contacts. Each client's emergency contact information (which includes parent/legal guardian, emergency contact and if applicable, service coordinator) will be located in the client records for employees to access as needed. The parent/legal guardian agrees to keep CRCC informed of all changes in contact information. If you are more than one hour late and CRCC has been unable to contact anyone listed on your child's enrollment forms, we will contact the appropriate authorities (i.e. Child Protective Services or Police).

_____ **I understand my child may only be released to authorized individuals listed by me at time of enrollment or as amended in writing.**

_____ **Drug and Alcohol Use:** CRCC will not release a client to any parent/legal guardian or authorized person who is suspected of impairment due to the influence of drugs or alcohol, and is unable to safely transport and care for the client. The judgment of impairment is made by observation from CRCC staff. The criteria used includes but is not limited to appearance, behavior and speech. CRCC expects compliance with an alternative plan for releasing a child, which may include calling an emergency contact person or local authorities for support.

_____ **Medications:** CRCC Nursing Services **will not** administer any medication to a client without prior consent from a physician/practitioner orders/detailed written instructions. This includes prescription medications as well as over the counter medications for common cold, fever, pain and allergy

Client Name: _____

Client DOB: _____

symptoms. Parent/legal guardian will need to provide a written physician order prior to medication administration. Parent/legal guardian will need to provide all prescribed or over the counter medications that are ordered for the client. I agree that CRCC may administer at their discretion: sunscreen, diaper rash ointment, alcohol wipes, anti-itch lotion, and antibiotic ointment.

_____ **Medication Administration Competency:** Medication is only administered by CRCC licensed nurses.

_____ **Payment for Services:** I have read, understand, and agree to follow the Payment Policy in the CRCC Parent Handbook. I have been informed that it is ultimately my responsibility to know and understand my financial responsibilities.

_____ **No Hire Agreement:** Current clients of CRCC may hire employees for temporary respite care (i.e. baby- sitting). All payment arrangements are between the parent and CRCC staff member providing the care. Employees may provide this type of care when and if it does not interfere with regular scheduled working hours of the staff member or the center's hours of operation. Employees providing respite care of current CRCC clients during Center business hours will be subject to disciplinary action. This would be a violation of professional ethics and Center policy.

_____ **Parent Handbook Receipt and Agreement to Policies:** I acknowledge the receipt of CRCC Parent Handbook, have read and agreed to abide by CRCC policies for the safety and care of my child as well as others.

I am/We are seeking care for _____(child's name) at CRCC which may include an array of social, medical, rehabilitation, or support services including, but not limited to, special needs child care and/or respite care. If the client is under the age of nineteen, or unable to give consent or enter into a legal agreement, I attest that I have legal custody of this individual and am legally authorized to initiate and consent for treatment on behalf of this individual. I hereby agree to abide by the above clauses.

By signing this, I acknowledge that I am a financially responsible party, I have read, understand and accept all above terms of enrollment in CRCC.

_____ _____

Parent/Legal Guardian Signature Date/Time

_____ _____

Parent/Legal Guardian Signature Date/Time

Name: _____

DOB: _____

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Notice of Privacy Practices
Acknowledgement of Receipt

Children's Respite Care Center, Inc. ("CRCC") is required by law to maintain the privacy of your protected health information and to provide you with the CRCC Notice of Privacy Practices (or "Notice"). The Notice describes how your protected health information will be used and disclosed, and it lists the instances when CRCC is permitted to disclose your protected health information without your authorization. Additionally, The Notice outlines your privacy rights, and includes information on how you may complain if you believe your privacy rights have been violated.

CRCC is also required to capture your written acknowledgement that you received this Notice. We have provided you with this Acknowledgement of Receipt to facilitate this requirement.

Acknowledgement:
I hereby acknowledge that I have been provided, and have been given an opportunity to review, a copy of CRCC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I may contact CRCC's Privacy Officer in person or by phone at 402.895.4000.

I understand that my refusal to sign this acknowledgement form does not prevent CRCC from using or disclosing my protected health information as permitted by law.

_____

Signature of Parent/Guardian Date

_____

Signature of Staff Member if refusal of Acknowledgment of Receipt Date

Date of NPP 1/15/2018

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CRCC PAYMENT POLICY

We are committed to the care and medical treatment of your child. Please understand that payment of our services is part of this care. CRCC contracts with NE DHHS, Medicaid managed care organizations, and other commercial insurance companies. As a courtesy, CRCC will assist families, when possible, in verifying insurance/funding eligibility and authorization requirements along with submitting claims and other paperwork to facilitate payment. However, keep in mind, it is your responsibility to know and understand your healthcare coverage and financial responsibilities. Please be sure to keep CRCC informed of any changes to your eligibility, insurance coverage, or authorization. To expedite services, families may opt to complete a Patient Assistance packet and receive a private pay rate for services while waiting for other funding to be in place. CRCC will provide care for two (2) weeks prior to charging the PA rate to families. When funding is in place, private pay will automatically be suspended. Any back pay received by CRCC will be credited to the family at that time. If the family chooses not to complete a Patient Assistance packet, funding must be in place prior to CRCC providing a start date, and the classroom slot will not be reserved.

PROGRAMS	FUNDING OPTIONS	OTHER
▪ Skilled Care / Day & Weekend	Nebraska Medicaid Childcare Subsidy (Title XX) Waiver programs	Self-Pay, Subsidized Care (Patient Assistance)
▪ Rehab Therapy	Nebraska Medicaid	Commercial Insurance, Self-Pay
▪ Behavioral Health Therapy	Nebraska Medicaid	Self-Pay, Commercial Insurance
▪ Preschool Program	Childcare Subsidy (Title XX)	Self-Pay

Pre- Authorization:
Most services provided by CRCC need to be pre-authorized before service can be provided. Any required paperwork or authorization support needs to be provided to CRCC or the requesting organization in a timely manner in order to attend, continue attending, or receive treatment. If you request services start before authorization is secured or fail to inform us that coverage or eligibility has lapsed, you will be responsible for the cost not covered by the third party payer.

Scheduling and Cancellation:
You are responsible for **scheduling services for your child by communicating** regularly with the Center staff. Make sure you understand any limits on number of visits or hours authorized by insurance or third

party payers, as it is your responsibility to pay any charges for services beyond the limit of what has been authorized or pre-approved to schedule.

In order for CRCC to provide quality, safe care in our day/weekend skilled care programs, we schedule in advance and drop-in care is not allowed. We rely on the scheduling information provided in order to staff each classroom appropriately at all times. Your child may be denied care on days that have not been scheduled in advance, OR if you show up one hour later than care was scheduled without proper notice and approval.

You must inform the Center in advance if any services need to be changed, cancelled or rescheduled. Please note, if you fail to cancel skilled care or therapy when your child is absent or pick up your child late (after closing time), you will be responsible for paying additional fees. If you repeatedly fail to cancel services or stay outside your reserved hours, we have the right to limit attendance and/or suspend services.

Fees:

In addition to charges for care or treatment, additional fees may be charged. These fees include:

- **$35.00 Registration Fee per child.** This fee is non-refundable and due upon enrollment. A client who does not use any CRCC service for one year and wishes to re-enroll will be charged a $35 re-enrollment fee.

- **$185.00 First week's tuition (Non-CDHS).** This down payment will go toward the child's first week of care but will be held as a non-refundable deposit prior to the child starting

- **$50.00 Summer Camp Activity Fee per child.** This fee is non-refundable and due when registering for Summer Camp.

- **$10.00 Late Fee** will be assessed when a child in Skilled Care is picked up on a weekday after 6:05pm. An additional $1.00 per minute will be billed to the client's parent/guardian for pickup later than 6:15. During weekend hours, the Late Fee will be assessed beginning five minutes after scheduled closing times.

- **$25.00 "No Show" Fee** per day. "No Show" fees are charged when your child is scheduled to attend or participate in any treatment or care, and you do not notify CRCC one hour prior to the scheduled start time.

- **$50.00 Overnight "No Show" Fee** will be charged if at least 6 hours advance notice is not provided for cancelling an overnight or weekend stay reservation.

- **$25.00 Insufficient Funds Fee** will be charged for credit card, debit card, or personal check returns showing insufficient funds. To avoid this fee, be sure CRCC is made aware of any changes of accounts that are on file and that funds are available on the scheduled withdrawal dates.

Client Name: _____

Client DOB: _____

Billing:

Skilled care is billed based on attendance or services provided. We charge a minimum of one hour of care per day when a child attends and then in 15 minute increments thereafter. CRCC will submit claims to applicable third party payers based on the funding/insurance information provided. Any portion owed by the family will be charged on weekly statements. Charges to families may include private or self-pay rates, patient assistance rates, and family copayments, deductibles, or co-insurance. Families may also be responsible for any unpaid or denied charges due to exceeding authorized visits / hours and changes to eligibility and/or coverage.

Payment from the family must be remitted by the Friday following any week in which the child attended. All copayments will be charged based on attendance or are due the 1st of the month. A weekly statement of activity, including charges and payments, is provided showing the balance due. Statements are available at the front desk by the Tuesday following attendance for the previous week and payment must be remitted by Friday.

Peer Model Preschool Billing ($185 weekly) is billed the Friday the week prior to attendance. Payments are due by charge card.

Payment may be made via check, cashier's check, credit/debit card or cash. Charges to credit and debit cards will be processed every Friday. If your payment is not received by end of day Friday, attendance may be put on hold until payment is received or arrangements made with the billing department. The organization requires that a credit or debit card be placed on file with the organization as a back-up method for payment.

Any additional fees incurred will be billed to you and are due upon receipt. You may inquire about your account at any time by calling the billing office at 402-895-4000 or emailing BillingTeam@crccomaha.org

CRCC reserves the right to refuse services to any client whose account is not in good standing. If you receive payment directly from a payer for any service CRCC has provided, it is your responsibility to reimburse CRCC in full and provide CRCC with a copy of the Explanation of Benefits received with the reimbursement.

By signing this, I acknowledge that I am a financially responsible party, I have read, understand and accept all above terms of enrollment in CRCC.

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Date

☐ Enrollment fee

☐ Weekly charges

Name: _____

DOB: _____

Credit Card Information

Charges to families may include private or self-pay rates, patient assistance rates, and family copayments, deductibles, or co-insurance. Families may also be responsible for any unpaid or denied charges due to exceeding authorized visits / hours and changes to eligibility and/or coverage.

Payment may be made via check, cashier's check, credit/debit card or cash. If you elect to pay weekly charges using credit and debit cards please check box above. Charges will be processed every Friday. Receipt will be emailed if you have provided an email address below.

In addition - CRCC requires that a credit or debit card be placed on file with the organization as a back-up method for payment.

Client Name: _____ DOB: _____ Today's Date: _____

☐ MasterCard ☐ Visa

Card Number:_____

Name as it appears on the card:_____

Expiration date:_____ 3-digit V-Code_____

AUTHORIZATION TO CHARGE TO THE CARD:
I authorize CRCC to charge my credit card for services elected above and / or any unpaid balances. I understand I have a right to be notified of charges made to my account and to request a detailed invoice and receipt of any charges or payments.

Signature:_____ Date: _____

Print Name: _____

Email address: _____

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Name: _____

DOB:

CRCC
Right to Use Photographic Likeness-
Consent, Waiver of Liability and Release

I, _____(parent) hereby authorize and grant to CRCC the right to use photographs ("Photographs") taken of my minor child or adult child of protected person status, _____ at any time and for any purpose relating to the operations of CRCC or the services provided by CRCC, including but not limited to advertising and fundraising purposes.

I relinquish and give to CRCC all right, title and interest in the Photographs, finished pictures, negatives, reproductions, and copies of the original prints and negatives, and further grant CRCC the right to give, sell, transfer, and exhibit the Photographs for the foregoing purposes. I acknowledge and agree that my child may be included in the Photographs in whole or in part, in composite or distorted form, or in reproductions thereof, in color or otherwise, in conjunction with my own or a fictitious name, made and published through any medium including, but not limited to, any printed medium, video, and/or on the internet. The authorizations granted to CRCC herein will not violate any other person's rights. CRCC shall not be obligated to compensate me or my child in any way for any use of the Photographs. I understand and agree that CRCC shall be the exclusive owner of all right, title and interest, including copyright, in works of authorship which it creates and which incorporates the Photographs.

This consent authorizes both any initial and any subsequent publication or disclosure of the Photographs with or without my or my child's identity at any time unless the consent provided herein has been revoked, as set forth below.

I waive any right that I may have to inspect or approve the finished product or the advertising or other copy that may be used in connection therewith and incorporating the Photographs; provided such use is consistent with the purposes set forth above.

I release and discharge CRCC and its employees, officers, agents and assigns (collectively, the "Released Parties"), from any and all liability by virtue of any blurring, distortion, alteration, optical illusion, or use in composite form whether intentional or otherwise, that may occur or be produced in the taking or use of the Photographs, or in any processing toward the completion of any finished product using the Photographs. I further release the Released Parties from any and all liability costs, claims, damages or expenses resulting from CRCC's use of the Photographs as provided herein, or resulting from the unauthorized use of the Photographs by any person.

I understand that the terms herein are contractual and not a mere recital, that this instrument is legally binding, and that I have voluntarily signed this document on my behalf and on behalf of my child.

I understand that the authorizations granted herein shall remain in effect until revoked by me in writing. Any revocation shall be prospective only. Except to the extent that CRCC has taken action in reliance on the authorization granted herein, I understand that I have the right to revoke this consent by giving written notice to CRCC. I understand the Photographs and information related thereto may be subject to redisclosure by CRCC and may no longer be protected by the HIPAA final privacy rule.

I HAVE FULLY INFORMED MYSELF OF THE CONTENTS OF THIS CONSENT, WAIVER OF LIABILITY AND RELEASE BY READING IT BEFORE SIGNING IT ON BEHALF OF MYSELF AND MY MINOR CHILD.

☐Yes

Parent/Guardian Signature: _____

_____
Date

☐No
Reason: _____

OFFICE USE ONLY:

☐FAMCare
☐Client Schedules
☐Attendance Email

SCHEDULE FOR CARE AGREEMENT

This agreement contains the terms for care services based on the schedule of care for the following child(ren) (name(s) & DOB): _____ which are agreed upon between Children's Respite Care Center, and their parent(s)/legal guardian(s).

Child Care is used while the Parents are *both* at work or school, plus half hour travel time on either side of work/school hours. Respite is when *one or both* parents are not at work or school. Most funding sources specifies that care is for either child care or respite. You must declare what your hours at CRCC will be used for. Please clarify if unsure.

The hours and days agreed upon for care are as follows:

DAY	FROM (AM/PM)	TO (AM/PM)	FROM (AM/PM)	TO (AM/PM)	HOURS	These hours are for: (Work or Respite)
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Sunday						
This schedule is effective starting:				Weekly		

Two weeks advance notice is required for permanent changes in schedule. A new form must be submitted, signed and approved by the Program Director. If a client is absent for three or more days due to an acute illness or planned medical procedure, exceptions must be requested in writing. **Even if your funding source does not have a parent portion, you must make a Schedule Agreement.**

We ask that you adhere to this schedule as closely as possible because we schedule staffing based on attendance in each classroom every hour of the day. This allows us to provide quality care through lower ratios.

As per the Payment Policy, CRCC bills weekly after care has been provided and will charge a minimum of one hour of care per day and then in 15 minute increments thereafter.

By signing this form, we/I the Parent(s)/Legal Guardian(s) acknowledge this schedule will be used for reserving care for our child(ren). We/I have read the Payment Policy and acknowledge additional fees may be applied such as Late Fees, Insufficient Funds and No Show Fees if incurred.

Parent/Guardian's Signature:_____Date:_____

CRCC Director's Signature:_____Date:_____

Name: _____

DOB: _____

CRCC Policy for Attendance

Full-Time:

SCHEDULED over 30 hours a week- (attendance must also AVERAGE over 30 hours a week in a one month period and be regularly scheduled). Priority for space and scheduling is given to these clients. A Schedule for Care Agreement must be on file and followed, with any permanent changes made with a new schedule for Care Agreement two weeks before the changes are effective.

If attended hours drop below 30 hours a week in a one month (30 day) period, the client will drop to Part-Time status.

Part-Time:

SCHEDULED between 15 and 29 hours – (attendance must also AVERAGE between 15 and 29 hours a week over a one month period and be regularly scheduled). Part Time clients will be scheduled around the space left available by full time clients. A Schedule for Care must be on file and followed, with any permanent changes made with a new Schedule for Care Agreement two weeks before the changes are effective.

If attendance drops below 15 hours a week in a one month (30 day) period, the client will drop to Casual/Space Available status.

Casual/Space-Available:

SCHEDULED under 15 hours a week- (attendance will vary and care may be denied if there is not space at the requested time). Clients must schedule care at least one week in advance, in writing, and space is not guaranteed. If care is not scheduled for over 90 days, a 14 day notice will be sent. If no care is schedule during that 14 day period, the client will be notified and discharged.

Please sign below acknowledging you have read and understand our updated attendance policy.

Name of Client:_____

Parent/Guardian Signature:_____ Date:_____

Receipt of Parent Information Brochure

Child Care Program Name: _____

Enrolled Child(ren)'s names: _____

Parent/Guardian Names: _____

Parent/Guardian Signature; _____ Date: _____

Sign, date and return to your Child Care provider before your child(ren) begin care. Your Child Care provider must retain this Receipt on site for review.

Contact Information for Child Care Licensing

The following information may be of help in gathering information about Child Care Licensing and includes a mailing address, phone numbers and websites.

For questions regarding Child Care Licensing:
800-600-1289 (toll free)
Child Care Licensing
Department of Health and Human Services
PO Box 94986
Lincoln, NE 68509-4986
dhhs.ne.gov/publichealth/Pages/crl_childcare_childcareindex.aspx

Review or request a copy of Child Care Licensing Regulations:
dhhs.ne.gov/reg_1991.aspx
Phone: 800-600-1289

Report suspected Child Abuse/Neglect Hotline:
800-652-1999

Child and Adult Care Food Program
800-731-2233
www.education.ne.gov/NS/cacfp/index.html

Review or request a roster of Licensed Child Care Providers:
dhhs.ne.gov/publichealth/Documents/ChildCareRoster.pdf
Phone: 800-600-1289

Additional Resources

These resources may be of additional interest to you:

Child Care Subsidy (ACCESS Nebraska)
accessnebraska.ne.gov

Nebraska Dept of Health and Human Services
dhhs.ne.gov

Nebraska Immunization
dhhs.ne.gov/publichealth/Pages/immunization_index.aspx

State of Nebraska
nebraska.gov

Child Care Licensing
dhhs.ne.gov/publichealth/Pages/crl_childcare_childcareindex.aspx

National Children's Coalition
teenpregnancy.org

Report Negative Actions:
dhhs.ne.gov/publichealth/Pages/crl_reportnegativeactionreports.aspx

Make a complaint:
dhhs.ne.gov/publichealth/Pages/crl_childcare_complaints.aspx
Phone: 800-600-1289

CRED-PAM-24 Rev. 12/14 (09/24)
(Previous version should be used)

Department of Health & Human Services

DHHS

NEBRASKA

Division of Public Health

Parent Information Brochure For Licensed Child Care

Licensed Child Care

You have chosen to use a licensed Child Care provider for the care of your child or children.

According to Nebraska State law (Neb. Rev. Statute 71-1909), the licensing and regulation of Child Care programs exists to protect children and to assist parents in making informed decisions about the enrollment and care of their children in Child Care programs. These licensing and regulatory responsibilities are within the Department of Health and Human Services (DHHS).

Nebraska Law requires anyone providing care to four or more children from different families, for compensation, to be licensed.

The Types of Licensed Child Care in Nebraska are:

- Family Child Care Home I
- Family Child Care Home II
- Preschool
- Child Care Center
- School-Age Only Center

Roles and Responsibilities of Child Care Licensing

The roles and responsibilities of DHHS Child Care Licensing staff are to ensure that programs are providing proper care for and treatment of the children they serve, and that the care and treatment are consistent with the child's physical well-being, safety, and protection.

Licensed Child Care programs are encouraged to involve you. We urge you to let your Child Care provider's staff know of any concerns. There may be situations where you believe that the program is not responding to your concerns or may not be meeting state licensing standards. This brochure, which Child Care providers are required to share with you, provides information that might be helpful in those situations. Please complete the receipt section and return it to your Child Care provider. This will be kept with your child's records.

Responsibilities of Licensed Child Care Providers

Licensed Child Care providers should:

Comply with child care regulations for their license type at all times.

Obtain and maintain accurate records for children they have in care, such as Enrollment Forms, Parent Information Brochure Receipts, Immunization Records and Medication Administration records.

Keep accurate and up-to-date records for their license and staff members. Report changes to Child Care Licensing and complete required paperwork to reflect changes.

Allow access to their licensed facility when children are in care at all times to parents, Child Care Licensing representatives and the Fire Marshal.

Develop policies and procedures for their programs.

Communicate with families their needs and concerns for the children in care.

Contact Child Care Licensing with any question or concerns they may have.
800-600-1289
402-471-9278 or
dhhs.ne.gov/publichealth/Pages/crl_childcare_childcareindex.aspx

Expectations of Child Care Consumers

As a consumer of Licensed Child Care you should:

Read thoroughly all the information your provider gives you.

Complete your Child's Record Forms and return to your provider before your child begins care. Review and update these records as needed.

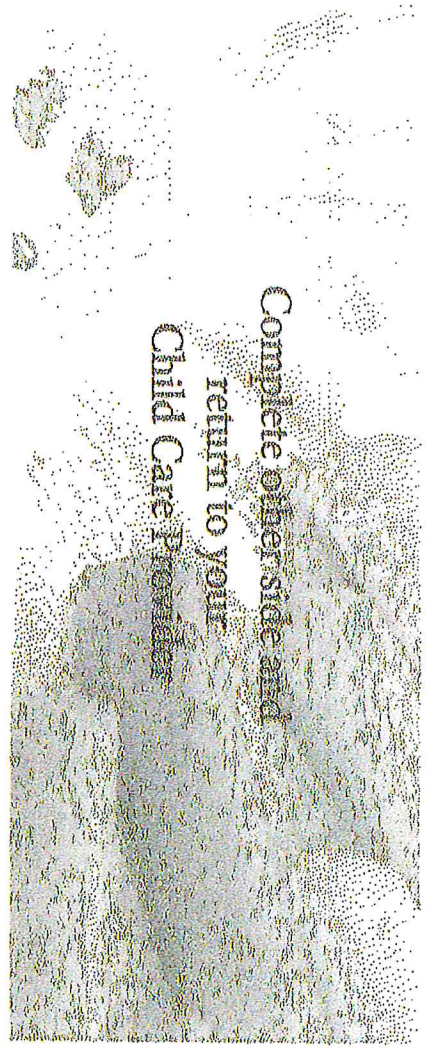
Supply your provider with your child's immunization records and keep them updated as needed.

Sign and date the receipt of this Parent Information Brochure for Licensed Child Care and return it to your provider before your child begins care.

Talk to your Child Care provider regularly to address needs and concerns for your children in care and as a parent.

Be informed of the child care regulations. Make sure you know what your licensed child care provider is regulated to do or not do.

Contact Child Care Licensing with any questions or concerns you may have.
800-600-1289
402-471-9278 or
dhhs.ne.gov/publichealth/Pages/crl_childcare_childcareindex.aspx



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Name: _____

DOB: _____

Client Name: _____

Key Card Acknowledgment

CRCC believes in providing a safe and secure environment, not only for the children and for the families, but also for the staff employed.

Upon your child(s) admission to CRCC, a key card for access to the center will be activated for primary parents or guardians who will be picking up or dropping off their child regularly. Each parent or guardian dropping off or picking up their child(ren) will be issued a key card which they, and only they, can use to access the building. We ask that you do not share your key card with other individuals, even if they have your permission to pick up your child. We want to limit access to the building for security reasons, so all others needing to enter the building should use the white "door bell".

In the event that a key card is lost or misplaced, you will be responsible for the replacement card at the cost of **$5.00** per card. Please promptly notify the Site Director so the key card(s) can be deactivated immediately.

The key card must be returned to the Center's Site Director if, and when, your child(ren) stops attending CRCC. The card will be deactivated automatically upon termination of services.

I have read and understand the above information.

_____ _____

Parent or Guardian Date

_____ _____

Management Signature Date

For Internal Use Only

Cards Issued to:

Name	Date	By
Name	**Date**	**By**

Name: _____

DOB _____

crcc

Joy. Hope. Health.

Authorization for Release of Information

Client's Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

I authorize the following person or organization to:

☒ Receive Information from CRCC ☐ Provide Information to CRCC ☐ Both Receive and Provide Information

Name: Midwest Child Care Association-USDA Child & Adult Care Food Program (CACFP) Service

Address: 7701 Pacific St, Suite 200

City: Omaha State: NE Zip: 68114

Phone: 402.551.2379 Fax: 402.551.7198

The type and amount of information to be used or disclosed is as follows (include dates where appropriate):

- ☐ Complete records
- ☐ Immunization record
- ☐ IEP/IFSP/IPPreports
- ☐ Consultation reports
- ☐ PT/OT/Speech therapy summaries
- ☐ Behavioral assessments and/or progress notes
- ☐ Lab results/x-ray reports
- ☐ Admission or discharge summaries
- ☐ History/Physical exam (H&P report)
- ☐ Psychological or psychiatric evaluation(s)
- ☐ Communication related to care and treatment
- ☒ Other: Client health information as it relates to dietary and nutrition needs, household information, and family income as needed to allow participation in the CACFP food program.

I understand that the information in my child's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

For the purpose of:

☐ Ongoing communication for specialized care provided by CRCC.

☒ Other *Participating in the CACFP food program for child care centers.*

I understand that I have a right to revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of CRCC. If I do this, it will prevent any releases after the date it is received but can not change the fact that some information was sent or shared before that date. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand and agree that this Authorization will be valid and in effect until_____(one year) unless I choose to revoke it. I understand that after that date, no more information can be used or released to CRCC unless I sign a new Authorization like this one.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an authorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____

Signature of parent or legal guardian Date

INCOME ELIGIBILITY GUIDELINES

Effective from July 1, 2019 to June 30, 2020

HOUSEHOLD SIZE	FEDERAL POVERTY GUIDELINES ANNUAL	REDUCED PRICE MEALS - 185 % ANNUAL	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY	FREE MEALS - 130 % ANNUAL	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY
48 CONTIGUOUS STATES, DISTRICT OF COLUMBIA, GUAM, AND TERRITORIES											
1	12,490	23,107	1,926	963	889	445	16,237	1,354	677	625	313
2	16,910	31,284	2,607	1,304	1,204	602	21,983	1,832	916	846	423
3	21,330	39,461	3,289	1,645	1,518	759	27,729	2,311	1,156	1,067	534
4	25,750	47,638	3,970	1,985	1,833	917	33,475	2,790	1,395	1,288	644
5	30,170	55,815	4,652	2,326	2,147	1,074	39,221	3,269	1,635	1,509	755
6	34,590	63,992	5,333	2,667	2,462	1,231	44,967	3,748	1,874	1,730	865
7	39,010	72,169	6,015	3,008	2,776	1,388	50,713	4,227	2,114	1,951	976
8	43,430	80,346	6,696	3,348	3,091	1,546	56,459	4,705	2,353	2,172	1,086
For each add'l family member, add	4,420	8,177	682	341	315	158	5,746	479	240	221	111
ALASKA											
1	15,600	28,860	2,405	1,203	1,110	555	20,280	1,690	845	780	390
2	21,130	39,091	3,258	1,629	1,504	752	27,469	2,290	1,145	1,057	529
3	26,660	49,321	4,111	2,056	1,897	949	34,658	2,889	1,445	1,333	667
4	32,190	59,552	4,963	2,482	2,291	1,146	41,847	3,488	1,744	1,610	805
5	37,720	69,782	5,816	2,908	2,684	1,342	49,036	4,087	2,044	1,886	943
6	43,250	80,013	6,668	3,334	3,078	1,539	56,225	4,686	2,343	2,163	1,082
7	48,780	90,243	7,521	3,761	3,471	1,736	63,414	5,285	2,643	2,439	1,220
8	54,310	100,474	8,373	4,187	3,865	1,933	70,603	5,884	2,942	2,716	1,358
For each add'l family member, add	5,530	10,231	853	427	394	197	7,189	600	300	277	139
HAWAII											
1	14,380	26,603	2,217	1,109	1,024	512	18,694	1,558	779	719	360
2	19,460	36,001	3,001	1,501	1,385	693	25,298	2,109	1,055	973	487
3	24,540	45,399	3,784	1,892	1,747	874	31,902	2,659	1,330	1,227	614
4	29,620	54,797	4,567	2,284	2,108	1,054	38,506	3,209	1,605	1,481	741
5	34,700	64,195	5,350	2,675	2,470	1,235	45,110	3,760	1,880	1,735	868
6	39,780	73,593	6,133	3,067	2,831	1,416	51,714	4,310	2,155	1,989	995
7	44,860	82,991	6,916	3,458	3,192	1,596	58,318	4,860	2,430	2,243	1,122
8	49,940	92,389	7,700	3,850	3,554	1,777	64,922	5,411	2,706	2,497	1,249
For each add'l family member, add	5,080	9,398	784	392	362	181	6,604	551	276	254	127

CRCC NW

INCOME ELIGIBILITY & ENROLLMENT FORM FOR CHILD CARE CENTERS
JULY 1, 2019 THROUGH JUNE 30, 2020

Revised 3/2019

Part 1. CHILD ENROLLMENT: Complete the information below for all children in care. If the child is an infant, foster child (legal responsibility of a foster care agency or the court), Head Start eligible or a school-age child, please check the box.

Last Name, First Name	Date of Birth	Enroll Date	Times of Care (Usual)		Usual Days of Care							Meals Served During Care						Infant	School Age	Head Start	Foster Child
			Arrival Time	Leave Time	M	T	W	T	F	S	S	B	AM	L	PM	D	EV				
																		☐	☐	☐	☐
																		☐	☐	☐	☐
																		☐	☐	☐	☐
																		☐	☐	☐	☐
																		☐	☐	☐	☐

OPTIONAL: Please check the ethnicity and race of the child(ren) you are enrolling.

Ethnicity (select one or more): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (select one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White or Caucasian

Part 2. Household Receiving Benefits: Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR): Complete Parts 1, 2 and 4.

Check Applicable Program & Provide Case Number(s): ☐ SNAP Case #:_____ ☐ TANF Case #:_____ ☐ FDPIR Case #: _____

Part 3A. HOUSEHOLDS EXCEEDING THE INCOME GUIDELINES: Complete Parts 1, 3A and 4.

If your family income exceeds the income guidelines (listed on attached letter), check this box ☐

Part 3B. ALL OTHER HOUSEHOLDS – If you do not have a SNAP, TANF or FDPIR *MASTERCASE* number: Complete Parts 1, 3B and 4.

List the Names of All Household Members not listed in Part 1 and Foster Children	GROSS INCOME BEFORE ANY DEDUCTIONS (Net for Self Employed) W=Weekly E2=Every 2 weeks 2M=Twice monthly M=Monthly Y=Yearly								
	Earnings from Work		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		All Other Income		Check if ZERO Income
	How much?	How often?	How much?	How often?	How much?	How often?	How much?	How often?	
1									☐
2									☐
3									☐
4									☐

Social Security Number of Household Member who signs form:

Last four digits of Social Security Number: XXX- XX -_____ If you do not have a Social Security Number, check this box ☐

Part 4. SIGNATURE AND CONTACT INFORMATION:

I certify (promise) that all information on this form is true and that all income is reported. I understand that the facility will receive Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose their meal benefits, and I may be prosecuted.

Signature of Parent/Guardian _____ Date _____

Print Name _____

Address _____

City _____ State _____ Zip Code _____

E-Mail Address/Telephone _____

FOR CENTER USE ONLY

_____ SNAP/TANF/FDPIR HOUSEHOLD

_____ ANNUAL INCOME:_____ HOUSEHOLD SIZE: _____

Center Official Signature _____ Date of Signature _____

Effective Date _____ Expiration Date _____

HOUSEHOLD CATEGORY: ☐ Free ☐ Reduced ☐ Paid ☐ Incomplete

Foster Child – Free Category
List name of foster child(ren)
_____

Client Health Information Update

Your help is needed to update your child's health status.

Parents: please complete, sign and return as soon as possible.

General Information: (to be completed by parent or caregiver)

Child's Name: (First, Last, MI) _____ Date of Birth: _____

Parent/Guardian: (First, Last) _____

Child's Current Address: _____

Home Phone: _____ Work Phone: _____

Health Provider Information:

Primary Physician: (Name, Address, Phone) _____

Specialty Physician: (Name, Address, Phone) _____

General Health Information:

Current Weight: _____ Recent surgery or Hospitalization: _____

Allergies: _____

Severity: ____Mild____Moderate____Severe Treatment: _____Epipen_____Benadryl

If you checked any of the above, please specify symptoms, treatment, restrictions and needed adjustments: _____

_____

_____

Diet: ☐Special Diet: _____

☐Formula/Breastmilk _____ ☐ Age Appropriate

Significant Health Conditions: _____

_____

_____

Immunizations up-to-date: ☐ **Please attach immunization record**

Current medications: ☐ None or Describe (Medication name, dose, route, schedule)_____

_____

_____

_____

List any family changes, behavior changes or other concerns you have regarding your child:_____

_____

_____

Signature of Parent/Guardian: _____

Date:_____