Dr. Day Care
Learning Center

Enrollment Packet

If completing on your computer: save this PDF *before* entering data and again when finished. Email, fax, or drop off completed packet.

Phone: 401-475-7707 Fax: 401- 231-5048
Email: info@drdaycare.com
Home Office Mailing Address: 1201 Douglas Pike, Suite 4, Smithfield, RI 02917

Today's Date: _____ Start Date: _____

Child's Name: _____ Site Name: _____

How did you hear about Dr. Day Care or Kids Klub?
To whom may we thank for referring you to our program? _____

Enclosed you will find the necessary documents to register your child at Dr. Day Care Learning Center. Please complete this Enrollment Application in order to enroll your child in a Dr. Day Care Learning Center, please contact the Site Administrator regarding availability and scheduling.

Required:

- ☐ Completed Enrollment Packet
  - Registration Form
  - Emergency Consent
  - Parent Authorization
  - Method of Payment Agreement
  - Parent Agreement Contract
  - Developmental History pages
    - Infant and Toddler, Preschool, or School Age
  - Meal Benefit Form
  - Meals Served Enrollment Form
- ☐ Physical and Immunization Records
  (updated annually and after every doctor visit)
- ☐ Registration Fee*
- ☐ First Week's Tuition
- ☐ Family photo for classroom
- ☐ Confirmed start date with Site Administrator

If applicable:

- ☐ DHS Child Care Subsidy
- ☐ DHS Absenteeism Form Letter
- ☐ Infant Meals

Elementary School Attending:

(for School Age students)

_____

Current Grade: _____

(indicate next year's grade if enrolling during summer break)

Note: if your child is taking medication that needs to be administered during the center's hours, a parent must sign a Medication Permission Form accompanied with a prescription or written order.

For your information:

- ☐ Building for the Future
- ☐ Women, Infants, And Children (WIC)
- ☐ CACFP Meal Benefit Instructions & Letter to Parents
- ☐ Dr. Day Care Information

*** $5 of each child's Registration fee will be donated to Hasbro Children's Hospital**

To Benefit

Hasbro Children's Hospital
The Pediatric Division of Rhode Island Hospital
Lifespan. Delivering health with care.®

This Enrollment Packet can also be found on our website: www.drdaycare.com/enroll

Dr. Day Care
Learning Center

Registration Form

Child's Information

Child's Name _____ ☐ Female ☐ Male Nickname _____
(first, middle, last)

Date of Birth _____ Child's Address, _____
Town, State & Zip _____

Child's Physical Description

Eye Color _____ Hair Color _____

Height _____ Weight _____

Birthmarks _____ Racial/Ethnic Identity _____

Additional Identifying Features _____

Administrator will attach a photo here from Procare

Parent/Guardian Information

Parent/Guardian #1		**Parent/Guardian #2**	
Relationship to child		Relationship to child	
Address		Address	
Town, State & Zip		Town, State & Zip	
Driver's License #		Driver's License #	
Health Insurance		Health Insurance	
Coverage Number		Coverage Number	
Employed By		Employed By	
Preferred Phone #		Preferred Phone #	
Business Telephone #		Business Telephone #	
Home Telephone #		Home Telephone #	
Cell Telephone #		Cell Telephone #	
Email Address		Email Address	

Emergency Contact Information

The following individual(s) may pick up my child as needed for departure and/or emergencies. I understand that any individuals not listed will not be allowed to pick up unless I provide written permission in advance. Proper Photo ID is required for pick up of your child. All emergency contacts must be 18 years or older.

Name		**Name**	
Relationship to child		Relationship to child	
Preferred Phone #		Preferred Phone #	
Address, Town, State & Zip		Address, Town, State & Zip	
Driver's License #		Driver's License #	
Email Address		Email Address	
Name		**Name**	
Relationship to child		Relationship to child	
Preferred Phone #		Preferred Phone #	
Address, Town, State & Zip		Address, Town, State & Zip	
Driver's License #		Driver's License #	
Email Address		Email Address	

Are there any circumstances regarding your child's release? ☐ Yes ☐ No

Any special instructions, such as custody or restraining orders must be attached to this application and discussed personally with the Administrator. All information will be kept confidential.

Parent/Guardian/Emergency Contacts have permission to speak and sign off on information about the child's day.

Parent/Guardian Signature: _____ Date: _____

(revised 12/5/19)

Emergency Consent

Child's Name _____ Date of Birth _____

(first, middle, last)

I hereby authorize Dr. Day Care, Inc. to arrange for medical examination and/or treatment of my child should an emergency arise at school or on a field trip. It is understood that a conscientious effort will be made by the school to contact me at the emergency numbers I have provided before any medical action is taken. I would prefer to have my child, if the need arises, taken to (Hospital Name) _____. The choice of hospital may be limited by service or local rescue. I authorize Dr. Day Care to act as the agent of the parents in an emergency situation for the health and welfare of my child. I am responsible for the expenses involved if the services of a physician or hospital are required.

Child's Physician's Name _____

Physician's Address _____ Physician's Phone Number _____

Child's Chronic Health Conditions _____

Child's Medication and Dosage _____

All medication to be administered at the Learning Center must be accompanied by a Medication Permission Form. Please see an Administrator for details.

Child's Allergies* _____

Allergic Reaction Symptoms _____

Special Dietary Concerns _____

Complete an Allergy Action Plan with a physician's order detailing allergies. Please see an Administrator for details.

Parent Authorization

Field Trip Permission (ages 4 and older) ☐ Yes ☐ No ☐ Not Applicable

Field trips will be planned as part of the Dr. Day Care Program for children over the age of 4. This will include walking to nearby areas as well as outdoor activities involving bus and/or van transportation. Every possible precaution will be exercised to assure the safety and welfare of your child. However, all authorized agents shall not be responsible, financially or otherwise, should any accidents occur. This checked box gives Dr. Day Care staff permission to take your child on any field trips and participate in any special presentations (example: puppet shows, storytellers, etc.). If any special circumstances, regarding field trips or presentations, apply to your child please notify your Administrator in writing immediately.

Photograph and Video Permission

☐ Yes I give Dr. Day Care staff permission to take photographs and/or videos of my child for public relations and /or marketing purposes. This includes the Parent Engagement app that is used to send daily updates to parents. Photos will remain archived at Dr. Day Care Home Office and can be used for promotional purposes without notification.

☐ No My child may not have photographs or videos used for public relations or marketing purposes. I understand that photographs will not be inlcuded in the Parent Engagement app that is used to send daily updates. **Please select "No" if your child is a foster child in DCYF custody.** Photos of my child may still be used in the classroom **only** for educational purposes (ie, Cubby Tags, Portfolios, etc).

School Department Permission (School Age Only) ☐ Yes ☐ No ☐ Not Applicable

I give Dr. Day Care staff permission to obtain medical and federal food program forms from the elementary school's designee. I give Dr. Day Care staff permission to communicate with school department teachers/ staff regarding homework and tutoring assistance for my child.

Dr. Day Care programs are designed to enhance and reinforce each stage of your child's development. If concerns or questions should arise regarding your child's participation, all parties will reach a solution. Dr. Day Care enjoys your child and provides a happy, healthy, educational and enriching environment for them and hopes to meet your expectations. If you have any concerns about any of the above listed, please make a note here:

_____

_____

Parent/Guardian Signature: _____ Date: _____

Method of Payment Agreement

Child's Full Name _____ Site of Enrollment _____

Please check (√) a preferred payment method. All payments must be received by the Friday of each week prior to the week of service. Our billing system automatically charges a late fee on Monday morning.

☐ Payment Plan Option 1 – Automatic Bank Draft (weekly draft from checking or savings account)

Name on the Account: _____ ☐ Checking ☐ Savings

Address, State, & Zip Code: _____

Account Holder's Phone #: _____ Name of the Bank: _____

Routing Transit Number: _____ Account Number: _____
(attach voided check)

Authorized signature: _____ Date: _____

I authorize Kids Klub, Inc./Dr. Day Care to deduct $_____ on Friday of each week prior to the week of service from my account with the financial institution named above for payment of my weekly child care tuition. I understand that I have the right to stop these automatic payments upon 14 days written notice to Kids Klub, Inc./Dr. Day Care prior to the time my account is charged. I also understand that Kids Klub, Inc. reserves the right to end this payment plan and my participation therein. I understand that transactions returned unpaid by my financial institution will result in fee being added to my Kids Klub Inc./Dr. Day Care account.

Please start with the billing cycle beginning _____ (month) _____ (day) _____ (year).

Authorized signature: _____ Date: _____

☐ Payment Plan Option 2 – Automatic Credit Card (weekly charge to credit or debit card)

Type of account to be charged: ☐ Discover ☐ MasterCard ☐ Visa

Name as it appears on the card: _____ Billing Address: _____

Account Holder's Phone #: _____ State and Zip Code: _____

Credit Card Number: _____

Expiration Date: _____ / _____ 3 digit Security Code _____
(on the back of the card)

Authorized signature: _____ Date: _____

I authorize Kids Klub, Inc./Dr. Day Care to deduct $_____ on Friday of each week prior to the week of service from my account with the financial institution named above for payment of my weekly child care tuition. I understand that I have the right to stop these automatic payments upon 14 days written notice to Kids Klub, Inc./Dr. Day Care prior to the time my account is charged. I also understand that Kids Klub, Inc. reserves the right to end this payment plan and my participation therein. I understand that transactions returned unpaid by my financial institution will result in a fee being added to my Kids Klub Inc./Dr. Day Care account.

Please start with the billing cycle beginning _____ (month) _____ (day) _____ (year).

Authorized signature: _____ Date: _____

☐ Payment Plan Option 3 – Pay weekly by Friday (cash, check, or card submitted weekly to the Site)

I understand that my account will incur a late fee each week that my account is past due, if payment is not submitted by Friday.

Authorized signature: _____ Date: _____

Dr. Day Care
Learning Center

Parent Agreement Contract

Start Date _____ Child's Name _____ Site _____

Please fill in the hours needed for the program on the corresponding day (for example, Tues 8:00- 5:00).

Monday	Tuesday	Wednesday	Thursday	Friday

The tuition for services will be: $_____per week, based on the above schedule. ☐ DHS copay

Full-time child care shall not exceed 50 hours per week, or 10 hours per day.

Weekly Method of Payment: ☐ Automatic Bank Draft ☐ Automatic Credit Card ☐ Pay Weekly

In consideration, I/we, as parent(s) or guardian, enroll or re-enroll our child(ren) at Dr. Day Care, Inc. with the understanding of the following:

- To secure a space for your child, a non-refundable registration fee and first week's tuition is required.
- A one-time Registration fee is charged per child or family upon enrollment. An annual Activity fee will be charged the 3rd week of September. Registration and Activity fees are outlined on the current year's tuition rate sheet.
- The tuition and registration payment is due on or before the first day your child begins care. Thereafter tuition is due the Friday before the upcoming week of service. If paying by check, please write your child's name on the memo portion of your check and the week your payment is for.
- Our billing system automatically charges a $15.00 fee to any account not paid by Monday morning.
- If hours of care for a child exceed the contracted amount, the parents/guardians will be subject to additional tuition for the overage in hours (i.e. 3 days of care to 4 days of care). Based on available space (tuition only)
- If weekly hours of care for a child exceeds what DHS approved for the family, the parents/guardians will be subject to a fee for the weekly overage in hours, which will be the difference between what the family is approved for by DHS and what hours were actually attended (i.e. 3/4 time to full time). Based on available space. (DHS subsidy only).
- Accounts in arrears may be subject to termination and parent/guardian is responsible for litigation.
- There will be a $35.00 charge for all returned checks.
- Late departures after closing are subject to a one dollar per minute late fee. After closing, if Dr. Day Care is unable to contact you or the emergency contacts provided, local authorities will be called after a reasonable amount of time has passed.
- No child will be cared for when sick with an infectious illness, for the well-being of your child, as well as others. Credit cannot be issued for a child who is out sick. For extended absences due to illness, parents may choose to use two week's vacation credit. Please speak with site Administrator or call our billing department (401-723-2277).

Parent Agreement Contract

- When terminating a child's enrollment, a one-week notice must be given in writing to the site Administrator. If no notice is given, your account will be billed accordingly.

- Vacation Credit - 2 weeks are allowed per year (Sep. – Aug.) at ½ of your regular tuition rate and you may have your child attend ½ time in day increments only. See Administrator for more information.

- To maintain proper staff/student ratio, agreed upon dates and times on this contract can only be altered when another contract is completed.

- Please contact your Administrator ASAP if you need to change any of your personal information or schedule (Examples: emergency person, address, home/work telephone numbers, times, fees, medical info, etc.)

- Dr. Day Care will be closed all Rhode Island holidays. Because holidays vary, please see your Administrator for a list of holiday closings. The center's hours and holiday schedules are set and posted annually, but may change at any time. The weekly tuition payments will remain the same. Note: part-time enrollees, if your child is scheduled to attend Dr. Day Care on a holiday, another day cannot be substituted because of staff/student ratio. Our program policy is to remain open unless the Governor declares a State of Emergency, we receive a state mandate, or unforeseen circumstances that compromise the safety of our children, staff, and families.

- Inclement Weather/ Professional Days/ Election Days- (this section is only applicable for children in our school age program) on days when the Elementary School is closed and Dr. Day Care is open, due to Inclement Weather, Professional Days, or Election Days, an additional fee will be added to your regular rate if your child attends. Charges are as followed: $20 additional if your weekly tuition is before and after school rate, $25 additional if your weekly tuition is after school rate, and $35 additional if your weekly tuition is before school rate. If a child is not scheduled for a given day and requires full day care, they will be charged the daily School Vacation rate.

- I hereby release Dr. Day Care, Inc., its officers, Administrators, and employees from all liability for injury to my child, in excess of the amount payable under the insurance carried by Dr. Day Care Inc.

- I agree that this Waiver and Release of Liability shall apply to each day my child attends a Dr. Day Care, Inc. and/or any related entity's facility regardless of the date this form is signed below. I agree that I will assume the risk and full responsibility for any and all injuries, losses, or damages, that might occur to my child or any other family members while on the premises or while participating in any off-site program or activity. I agree to waive and release any and all claims, suits or related causes of action against Dr. Day Care, Inc., and/or related entities, their owners, officers, employees, or agents for injury, loss, death, costs or other damages incurred by my child, me, my heirs or assigns, or any third parties for claims, suits or related causes of action asserted against Dr. Day Care Inc., and/or any related entities, arising from my child's conduct and/or my conduct and/or the conduct of my family members or guests while participating in any programs/activities. I further agree to release, indemnify and hold Dr. Day Care Inc., and/or any related entities, harmless from any liability whatsoever for any future claims presented by my child or any persons acting on my child's behalf for any injuries, losses or damages.

- I acknowledge that I received and reviewed the Family Handbook.

Dr. Day Care does not discriminate on the basis of race, color, sex, handicap, religion or national origin. Dr. Day Care reserves the right at their sole discretion to refuse an application or dismiss a child from our program.

Parent/Guardian #1 Printed Name: _____

Signature: _____ Date Signed: _____

Parent/Guardian #2 Printed Name: _____

Signature: _____ Date Signed: _____

Dr. Day Care
Learning Center

Developmental History Form - Infants & Toddlers (6 weeks- 35 months old)

Child's Full Name: _____ List child's family members: _____

Names and ages of child's siblings: _____

Child's Development

Does your child sit up? _____ Crawl? _____ Walk? _____ Talk? _____

Any speech difficulties or concerns? ☐ Yes ☐ No Language spoken at home? _____

Special words used to describe needs: _____

History of colic? _____ When? _____

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

What are your child's typical fussy behaviors? _____ When do these typically occur? _____

What has been the most effective to handle this time of day? _____

Health

Any known complications at birth? _____ Serious illnesses and/or hospitalizations? _____

Special physical conditions or disabilities? _____

Weight at birth? _____

Additional concerns? _____

Eating Habits

Types of food child eats: ☐ Bottle ☐ Jar Baby Food ☐ Table Foods Does your child use a bottle or sippy cup? _____

Describe child's self-feeding skills: _____

Food Restrictions or Concerns? _____

Sleeping Routines

Time child typically wakes up in the morning: _____ Does child usually sleep through the night? _____ Child's usual bedtime: _____

Who else shares the bedroom? _____ Daily nap schedule(s): _____

Additional Sleeping Notes/Suggestions: _____

For crib sleepers: Dr. Day Care follows the guidelines set forth by the American Academy of Pediatrics and places children on their backs during rest time. If you would like your child to be placed in a different position, please obtain a note from your child's pediatrician describing how to place your child in his/her crib.

We also do not place any items in your child's crib (except for a pacifier if specified by parent).

Diapers and Toileting

Are Disposable or Cloth diapers used at home? _____ Does child frequently get diaper rash? ☐ Yes ☐ No

Do you use ☐ Oil ☐ Powder ☐ Lotion ☐ Other: _____

Has potty training been attempted? ☐ Yes ☐ No Is there a problem with constipation or diarrhea? ☐ Yes ☐ No

Is child potty trained? ☐ Yes ☐ No Child's word for urination: _____ Bowel movements: _____

How does your child indicate bathroom needs (special words used)? _____

Is your child ever reluctant to use the bathroom? _____

Does your child have accidents? _____ How are they handled (words used, etc)? _____

Play and Social Relationships with Others

Child's typical personality: _____

Favorite Stories: _____ Favorite Toys: _____

How do you typically comfort your child? _____

What method of behavior management/discipline does your family use at home? _____

Typical reaction to strangers: _____ Does child play or have access to a yard? ☐ Yes ☐ No

Has child had other group experiences? ☐ Yes ☐ No Typically prefers to: ☐ Play alone ☐ Play with children ☐ Play with adults

If "yes," please check all that apply: ☐ Sunday School ☐ Nursery School ☐ Play Groups ☐ Child Care

For previous child care experiences, please provide additional information:

Program Name: _____ Program Name: _____

Dates attended: _____ Dates attended: _____

Reason(s) for leaving: _____ Reason(s) for leaving: _____

Does your child have any special needs or a diagnosis that we should be aware of? _____

Any additional information that may assist us in caring for your child (i.e. emotional, social, physical or behavioral information which would be important for us to know that includes specifics about his/her personality and temperament):

_____

_____

_____

_____

Ages 6 weeks – 35 months old

Dr. Day Care
Learning Center

Developmental History Form - Preschool (3 - 5 years old)

Child's Full Name: _____ List child's family members: _____

Names and ages of child's siblings: _____

Eating Habits

Likes: _____ Dislikes: _____

Time(s) of meals: _____ Typical Meal Routines: _____

Sleeping Routines

Time child typically wakes up: _____ Child's usual bedtime: _____

Does child usually sleep through the night? _____ Daily nap schedule(s): _____

Who else shares the bedroom? _____

Does your child require any special rest items? Please list them here: _____

Additional Sleeping Notes/Suggestions: _____

Dressing and Toileting

Can child dress self? ☐Yes ☐No Does child wear diapers? ☐Yes ☐No

Areas that need help: _____ Child's term for urination: _____

Comb his or her own hair? ☐Yes ☐No Child's term for bowel movement: _____

Manage zippers? ☐Yes ☐No Has potty training been attempted? ☐Yes ☐No

Manage buttons? ☐Yes ☐No Is child potty trained? ☐Yes (at what age: _____) ☐No

Does your child have accidents? _____ How are they handled (words used, etc)? _____

Discipline

How is your child disciplined at home? _____

Any special discipline concerns? _____

Does your child help around the house? ☐Yes ☐No How? _____

Play and Social Relationships with Others

Main play interests: _____

Favorite Stories: _____ Favorite Toys: _____

Does child play or have access to a yard? ☐Yes ☐No Types of equipment child is familiar with: _____

Typically prefers to: ☐Play alone ☐Play with other children ☐Play with adults

Has child had other group experiences? ☐Yes ☐No

If "yes," please check all that apply: ☐Sunday School ☐Nursery School ☐Play Groups ☐Child Care

Typical reaction to strangers: _____

How do you typically comfort your child? _____

What method of behavior management/discipline does your family use at home? _____

For previous child care experiences, please provide additional information:

Program Name: _____ Program Name: _____

Dates attended: _____ Dates attended: _____

Reason(s) for leaving: _____ Reason(s) for leaving: _____

Does your child have any special needs or a diagnosis that we should be aware of? _____

Any additional information that may assist us in caring for your child (i.e. emotional, social, physical or behavioral information which would be important for us to know that includes specifics about his/her personality and temperament):

Ages 3-5 years old

Dr. Day Care
Learning Center

Developmental History Form – School Age (Kindergarten – 12 years old)

Student's Full Name: _____ School attending: _____
Names and ages of siblings: _____ Pick up/Drop off times: _____
List student's family members: _____

Eating Habits

Likes: _____ Dislikes: _____
Time(s) of meals: _____ Typical Meal Routines: _____

Dressing and Toileting

Can child dress self? ☐ Yes ☐ No Areas that need help: _____
Does your child have accidents? _____ How are they handled (words used, etc)? _____

Discipline

How is your child disciplined at home? _____
Any special discipline concerns? _____
Does your child help around the house? ☐ Yes ☐ No How? _____

Play and Social Relationships with Others

Main play interests: _____
Favorite Stories: _____ Favorite Toys: _____
Does child play or have access to a yard? ☐ Yes ☐ No Types of equipment child is familiar with: _____
Typically prefers to: ☐ Play alone ☐ Play with other children ☐ Play with adults
Has child had other group experiences? ☐ Yes ☐ No
If "yes," please check all that apply: ☐ Sunday School ☐ Nursery School ☐ Play Groups ☐ Child Care
Typical reaction to strangers: _____
How do you typically comfort your child? _____
What method of behavior management/discipline does your family use at home? _____

For previous child care or after school experiences, please provide additional information:

Program Name: _____ Program Name: _____
Dates attended: _____ Dates attended: _____
Reason(s) for leaving: _____ Reason(s) for leaving: _____

Does your child have any special needs or a diagnosis that we should be aware of? _____

Any additional information that may assist us in caring for your child (i.e. emotional, social, physical or behavioral information which would be important for us to know that includes specifics about his/her personality and temperament):

Ages 5 - 12 years old

Physical and Immunization Records

Please contact your child's physician to get a copy of all medical records prior to enrollment and after **every** doctor visit.

School Name & Address:	STATE OF RHODE ISLAND SCHOOL PHYSICAL FORM	Health Care Provider Name and Address: Phone:

This form may substitute for any district-issued form. All districts must accept this form. General health examinations shall be documented in a standardized format with one copy available from the Rhode Island Department of Health or in any such format that captures the same fields of information (R16-21SCHO Section 8.4)

Student Name: Last	First	Middle	Date of Birth	Sex

Address: Street	Apt #	City	State	Zip Code	Home Phone

PLEASE COMPLETE ALL INFORMATION BELOW (May attach immunization transcript).

IMMUNIZATIONS	Please enter dates in MM/DD/YYYY format				
Hepatitis B					
Diphtheria-Tetanus-Pertussis DTP/DTaP	Check D if DT	Check D if DT	Check D if DT	Check D if DT	Check D if DT
Pneumococcal Conjugate PCV					
Polio					
Haemophilus Influenzae Type B Hib					
Measles-Mumps-Rubella MMR					
Varicella			D Student has history of varicella disease		
Tetanus-Diphtheria-Pertussis TdaP/Td	Check D if Td	Check D if Td	Check D if Td		
Rotavirus					
Hepatitis A					
Meningococcal					
HPV					

Immunization Exemption: [J Medical [J Religious

D Hep B D DTaP D PCV D Polio D Hib D MMR D Varicella D Td/Tdap D Rotavirus D Hep A D Mening D HPV

PHYSICAL EXAMINATION

Date of PE____/____/____ **Height**_____ **Weight**_____ **BP**_____

Please note any health problem, chronic health condition or disability that may affect behavior or health at school:

ASTHMA: No [J Yes [J **DIABETES: No [J Yes [J** **OTHER:** _____

Significant Systems Findings: _____

ALLERGIES: No [J **Yes [J (Please explain)**_____ **EPINEPHRINE AUTO-INJECTOR REQUIRED: No [J Yes [J**

Treatment Plan: _____

MEDICATION (REQUIRED AT SCHOOL): No [J **Yes [J (Please list)** _____

Other medication(s) that may affect behavior or health at school: _____

RESTRICTIONS: Can participate in physical education: Fully[J With limitation [J _____

Can participate in sports: Fully[J With limitation [J _____

LEAD SCREENING (Required for children < 6 years of age only)	SCOLIOSIS SCREENING	VISION SCREENING (Children entering Kindergarten)
Student is in compliance with lead screening requirements: Yes [J No [J	Yes [J No [J	[J Passed screening [J Screened and referred for comprehensive exam [J Referred for comprehensive exam, but not screened
TUBERCULOSIS (If required by school district) **Date of TB test:**		**Screening Date:** **Comprehensive Exam Date:**

HEALTH CARE PROVIDER SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____

Revised 7-10

DHS Child Care Subsidy

This page is for families which receive child care subsidy (CCACP) from the Rhode Island Department of Human Services (DHS). All forms must be filled out completely. If you do not receive DHS financial assistance you do not need to fill out this information.

Child's Full Name: _____ Site of Enrollment: _____

DHS Certificate Number: _____

Forms to complete:

- ☐ DHS Family Consent Form
- ☐ DHS Absenteeism Form Letters (in case of extended absences)
- ☐ Parent Agreement Contract Addendum
- ☐ Parent Provider Agreement Form **(Administrator prints from DHS website)**

DHS Family Consent Form

Today's Date: _____

To Whom It May Concern:

I *(parent name who is applying - please print)* _____ authorize the staff and members of Dr. Day Care/ Kids Klub, Inc. to advocate on my behalf with officials at the Rhode Island Department of Human Services. Further, I authorize the Department of Human Services to release and discuss any and all relevant information about my case with these representatives of the day care. Please contact me with any questions or concerns.

My child(ren)'s names:

_____

(Please list each child's first and last names)

Signed, _____

Address: _____ State & Zip Code: _____Home Phone #: _____

Parent Agreement Contract Addendum

If weekly hours of care for a child exceeds what DHS approved for the family, the parents/guardians will be subject to a fee for the weekly overage in hours, which will be the difference between what the family is approved for by DHS and what hours were actually attended (i.e. 3/4 time to full time).

(i.e. If a family is allowed ¾ time by DHS (CCAP) for a preschool child and they exceed 30 hours of care for their child a fee will be added for the additional child care services, which is the difference between the ¾ reimbursement rate and the full time reimbursement rate.)

Parent Signature: _____ Date: _____

DHS Absenteeism Form Letter

Rhode Island Department of Human Services
Office of Child Care
25 Howard Avenue, LP Bldg. 1st Floor
Cranston, R.I. 02920
(401) 462-6877

Child Care Assistance Program (CCAP)
Authorization for CCAP Payment During a Child's Absence

Families receiving CCAP benefits are eligible for up to two consecutive weeks of allowable absences at a time without impacting provider payment. Allowable absences include absences with notice that are accompanied by a parent notice (signed by the parent). Parental notice is required for absences that are five consecutive days in a week.

By completing the form below, you are authorizing DHS to provide payment to your child care provider during your child's absence from the program and you agree not to enroll your child with another child care provider during this time. **If you plan to take your child to another CCAP provider during this time, please do NOT submit this form, as DHS will not issue payment to more than one provider for the same hours of care.**

Provider ID:	
Provider Name:	
Parent Name:	
Certificate Number:	
Child(ren)'s Name(s):	
Dates of Child(ren)'s Absence:	
Reason for Absence:	

I certify that the information reported on this form is true and accurate.

Signature of Parent _____ **Date** _____

Signature of Provider _____ **Date** _____

Provider Printed Name _____ **Position/Title** _____

Providers: please ensure this form is complete, including parent signature, and upload with your attendance submission.
No CCAP payment will be made for absences longer than two consecutive weeks or for absences five days or longer that are not accompanied by an authorization for payment absentee form signed by the parent.

Infant Meals (for infants 6 weeks – 11 months old)

As a participant of the Child Care and Adult Food Program, Dr. Day Care provides either Walmart Parent's Choice Advantage iron-fortified formula or BJ's Wellsley Farms Advantage Premium Infant Formula Milk Based Powder with Iron for your child. We also offer baby cereal and jarred baby food at meal times. **If your child is under the age of 11 months and is not yet on table food**, please fill out and sign the lower portion of this form and return to your Administrator. Please see an Administrator or view website for a sample menu if your child is on table foods. If you have any questions or concerns, please see the Administrator.

Child's Full Name: _____ Dr. Day Care location: _____

Please check (✓):

☐ I will be providing my child's own formula or breastmilk.

☐ Please provide my child with iron-fortified formula. – *not available at Dr. Day Care Cumberland or Smithfield locations*

I understand that if I choose to have Dr. Day Care provide formula, I am responsible for supplying at least 4 clean, sterilized bottles, on a daily basis, labeled with my child's name, along with all bottle supplies (nipples, covers, liners, etc.) each day. At the end of each day, your child's bottles and supplies will be returned to you.

Has your child been exposed to other formulas or breast milk prior to utilizing the Dr. Day Care iron- fortified formula? ☐ Yes ☐ No

If yes, please list previous formulas here:

_____

☐ I will be providing my child's own baby cereal and/or jarred baby food.

☐ Please provide my child with baby cereal and/or jarred baby food.

Additional information that may assist us in the feeding of your child:

_____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date Signed: _____

USDA Nondiscrimination Statement: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, gender identity (including gender expression), sexual orientation, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident. Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the responsible Agency or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. USDA is an equal opportunity provider, employer, and lender. https://www.usda.gov/non-discrimination-statement

U.S. Department of Agriculture

Women, Infants, and Children Program (WIC)

- Pregnant or postpartum women, infants, and children up to age 5 are eligible for WIC.
- You must live in RI, and be individually determined to be at "nutritional risk" by a health professional, *AND*
- You must meet income guidelines.
  - A person or certain family members automatically meets the family income eligibility requirements by participating in Supplemental Nutrition Assistance Program (SNAP), Medicaid, or RIWorks *OR*
  - Your gross income (before taxes are withheld) must fall at or below 185 of the U.S. Poverty Income Guidelines:

WIC Income Eligibility Guidelines
(Effective from July 1, 2024 to June 30, 2025)

Household Size	Annual	Monthly	Twice-Monthly	Bi-Weekly	Weekly
1	27,861	2,322	1,161	1,072	536
2	37,814	3,152	1,576	1,455	728
3	47,767	3,981	1,991	1,838	919
4	57,720	4,810	2,405	2,220	1,110
5	67,673	5,640	2,820	2,603	1,302
6	77,626	6,469	3,235	2,986	1,493
7	87,579	7,299	3,650	3,369	1,685
8	97,532	8,128	4,064	3,752	1,876
Each add'l member, add	+$9,953	+$830	+$415	+$383	+$192

This institution is an equal opportunity provider.

What are the benefits?

WIC participants receive:

- Supplemental Nutritious foods
- Nutrition education and counseling at WIC clinics
- Screening and referrals to other health, welfare and social services

In RI, WIC participants receive WIC checks to purchase specific foods each month which are designed to supplement their diets. WIC foods include iron-fortified infant formula and infant cereal, iron-fortified adult cereal, vitamin C-rich fruit and/or vegetables juice, eggs, milk, cheese, peanut butter, dried beans or peas, tuna fish and carrots. Special infant formulas and certain medical foods may be provided when prescribed by a physician or health professional for specified medical condition.

Below is the RI WIC website
http://www.health.ri.gov/programs/wic/
Or
Call for information on sites near you.
Telephone: (401) 222-4623
Toll free (in-state): 1-800-942-7434
TDD: 1-800-745-5555

Meals Served Enrollment Form (CACFP)

To verify the enrollment of your child in this child care center complete the following information, sign and date this form and return it to the day care center. The Administrator will review this completed form before submitting to the Dr. Day Care Finance Department.

Dr. Day Care participates in the U. S. Department of Agriculture Child and Adult Care Food Program (CACFP). This program helps us provide nutritious meals and snacks to children enrolled at our center. The requirements and portion sizes for those meals and snacks are included as an attachment to this enrollment form. Under the regulations of the CACFP, you are not charged separate fees for meals nor may you be asked to provide food for your children for those meals or snacks claimed under the program. Regular day care fees cover the cost of care and food costs not reimbursed by the CACFP.

Check here ONLY if you are choosing **not** to enroll your child in CACFP, then sign and date the bottom of the form:

☐ *I **do not** want my child to participate in the Child and Adult Care Food Program (CACFP)*

To verify the enrollment of your child in this child care center complete the following information, sign and date this form and return it to the day care center.

Child's Full Name: _____ Dr. Day Care Location: _____

First Day of Attendance: _____ Month, Date & Year of Birth: _____ Age: _____

My child will normally be in child care during the following days and times and receive the meals as indicated below:

① Child Information			② Days of Attendance	③ Times Child Normally Attends During Week		*(If child leaves for School)*		④ Meals Served
Date of Birth / /	Age*	First Day of Attendance / /	☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday	Arrival Time	Departure Time	Leaves Center	Returns to Center	☐ Breakfast ☐ Lunch ☐ Snack

*For infants ages 6 weeks – 11 months old, please ALSO complete the Infant Meals portion of this form below

Parent/Guardian Printed Name: _____ Work Phone: _____ Home Phone: _____

Address (please print): _____

Parent/Guardian Signature: _____ Date Signed: _____

Administrator's Signature (Sponsor Representative): _____ Date Signed: _____

Building for the Future

This day care facility participates in the Child and Adult Care Food Program (CACFP), a Federal program that provides healthy meals and snacks to children receiving day care. Each day more than 2.6 million children participate in CACFP at day care homes and centers across the country. Providers are reimbursed for serving nutritious meals that meet USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

Meals CACFP homes and centers follow meal requirements established by USDA.

Breakfast	Lunch or Supper	Snacks (Two of the five groups:)
Milk Fruit or Vegetable Grains	Milk Meat or meat alternate Grains Fruit Vegetable	Milk Meat or meat alternate Grains Fruit Vegetable

Participating Facilities Many different homes and centers operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- **Child Care Centers:** Licensed or approved public or private nonprofit child care centers, Head Start programs, and some for-profit centers.
- **Family Day Care Homes:** Licensed or approved private homes.
- **Afterschool Care Programs:** Centers in low-income areas provide free snacks to school-age children and youth.
- **Homeless Shelters:** Emergency shelters provide food services to homeless children.

Eligibility State agencies reimburse facilities that offer non-residential day care to the following children:

- Children age 12 and under
- Migrant children age 15 and younger, and
- Youths through age 18 in afterschool care programs in needy areas

Contact Information If you have questions about CACFP, please contact one of the following:

Sponsoring Organization:
Dr. Day Care
1201 Douglas Pike, Ste 4, Smithfield, RI 02917
(401) 475-7707

Child Nutrition Programs
RI Department of Education
255 Westminster Street, Providence, RI 02903
(401) 222-4600

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This page is for your information. It does not need to be returned.

CACFP Meal Benefit Income Eligibility Form Instructions

The Child and Adult Care Food Program (CACFP) makes good food a regular part of your child's day care! Please fill out the CACFP Meal Benefit Income Eligibility form.

Step 1: List all the children from your household in the day care. Use one line for each child's name. Write one letter in each box. Stop if you run out of space. If there are more children, add their names on a second piece of paper.
Do you have any foster children? If you answer Yes, mark the Foster Child box next to the child's name. If you are only applying for foster children, finish Step 1 and go to Step 4. If you are applying for both foster and non-foster children, go to Step 2.
Are any children migrant, runaway, homeless, or enrolled in Head Start? If Yes, mark the correct boxes next to the child's name and go to Step 4.

Step 2: You qualify for free meals if you live in a household that receives Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR).
Do any household members, including you, currently receive SNAP, TANF, or FDPIR? If Yes, write the case number in the box and go to Step 4. You only need to provide one case number. If No, go to Step 3.

Step 3: Report current income for all household members. Skip this step if you answered Yes in Step 2.
How do you report child income? Turn the form over and use the Source of Income for Children chart to see if your household has income to report. Write the amount in the boxes in part A of the form. Mark how often the amount is earned. Write 0 in the box if there is no income to report.
How do you report income of adult household members? Turn the form over and use the Source of Income for Adults chart to see if your household has income to report. In part B, list all the adults in your household, including you, even if each of you doesn't receive income. Include all adults, such as grandparents, other relatives, and friends who live with you and share household income and expenses. Write the amount of income each of you receives, in the boxes next to your names. Mark how often the amount is received. Write 0 in the box if there is no income to report.
Make sure you report the current amount of money you get before taxes. Don't include SNAP, FDPIR, WIC, student financial aid, or money you receive for a foster child as income.
Count the number of all children and adults in your household. Include all infants, children, students, and adults. Write the total number in the box under the list of adult household members.
Do you or another adult household member have a Social Security number? Write the last four digits in the boxes. If there is no Social Security number, mark the Check if no SSN box.

Points to Remember:

If:	Then:
Your income isn't always the same	*List the amount of money that you normally get. For example, don't include overtime pay, if you don't normally get it. If your income is normally higher or lower, you can report annual income instead.*
Your household includes members who aren't citizens	*You or your children don't have to be U.S. citizens to qualify for meal benefits.*
You are in the military	*Don't include your Family Subsistence Supplemental Allowance (FSSA), combat pay, or the money you receive for privatized housing. If deployed, count the amount of pay that is made available to your household as income.*

Step 4: An adult household member must sign this form. The signer promises that all information is true and complete. Print the name, address, and telephone or email of the adult signer. Sign and write today's date in the marked boxes.

Optional
We ask about your children's ethnicity and race to make sure we do our best to serve our community. Providing this information is not required. You won't be denied benefits based on your race, color, national origin, sex, age, or disability.

Letter to Parents (Non-Pricing Centers)

Dear Parent or Guardian:

Dr. Day Care offers healthy meals and snacks to children as part of the Child and Adult Care Food Program (CACFP). We receive support from CACFP to serve those meals. CACFP gives more support if your household income is less than or equal to the limits on this chart:

Federal Income Standards for Reduced-Price Meals for July 1, 2024 - June 30, 2025

Household size	Yearly Income	Monthly Income
1	$27,861	$2,322
2	37,814	3,152
3	47,767	3,981
4	57,720	4,810
5	67,673	5,640

Please fill out a CACFP Meal Benefit Income Eligibility form. It will help us find out how much support Dr. Day Care receives. Please be sure to read the instructions carefully. Fill in all the information we request. We can only accept complete forms. Please send the completed form to your center Administrator.

Thank you for taking the time to fill out the form. We hope your child enjoys CACFP meals!

In the operation of child nutrition programs, no person will be discriminated against because of race, color, national origin, sex, age, or disability.

If you have questions or need help, please contact Dr. Mary Ann Shallcross Smith at 401-475-7707 or info@drdaycare.com

Dr. Mary Ann Shallcross Smith

Sponsor Representative Signature

This institution is an equal opportunity provider.

Visit https://vote.gov to find more information about local, state, and federal elections and how you can participate.
Check Voter Registration Deadlines and Laws in Your State at Vote.gov

CACFP Meal Benefit Income Eligibility (Child Care)

Complete one application per household. Please use a pen (not a pencil).

APPLY ONLINE:
Insert URL Here

STEP 1 List ALL children in day care (if more spaces are required for additional names, attach another sheet of paper)

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related."

Children in Foster care and children who meet the definition of **Homeless, Migrant** or **Runaway** are eligible for free meals.

Child's First Name	MI	Child's Last Name	Foster Child	Migrant	Runaway	Homeless	Head Start
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐

Check all that apply

STEP 2 Do any household members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR?

IF NO > Go to STEP 3 **IF YES >** Write case number here and proceed to STEP 4 (do not complete STEP 3)

CASE NUMBER:

Write only one case number in this space.

STEP 3 Total Household Gross Income (List only household members with income)

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

The **"Sources of Income for Children"** chart will help you with the Child Income section.

The **"Sources of Income for Adults"** chart will help you with All Adult Household Members section.

A. Child Income
Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here.

Child Income	How often? Weekly	Bi-Weekly	Monthly	Bi-Monthly
$	○	○	○	○

B. All Adult Household Members (Including yourself)
List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and last)	Earnings from Work	How often? Weekly	Bi-Weekly	Monthly	2x Month	Welfare/Child Support/Alimony	How often? Weekly	Bi-Weekly	Monthly	2x Month	Pensions/Retirement/ Social Security/SSI/ VA Benefits	How often? Weekly	Bi-Weekly	Monthly	2x Month
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○

Total Household Members (Children and Adults)

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or other Adult Household Member X X X X X ____

Check if no SSN ☐

STEP 4 Contact information and adult signature. MAIL COMPLETED FORM TO YOUR SCHOOL AT:

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Print Name of Adult Signing the Form

Signature of Adult

Today's Date

Address

City

State

Zip

Phone/Email

(revised 5/31/24)

Administrator's Initials: _______________Date: _____________

Administrator's Initials: _____ Date: _____
S:\Enrollment Packet\Dr. Day Care\Enrollment Packet_DDC.pdf

Source of Income for Children	
Sources of Child Income	**Examples**
Earnings from work	• A child has a regular full or part-time job where they earn a salary or wages
Social Security - Disability Payments - Survivors Benefits	• A child is blind or disabled and receives Social Security benefits • A parent is disabled, retired, or deceased, and their child receives Social Security benefits
Income from person outside of household	• A friend or extended family member reguarly gives a child spending money
Income from any other source	• A child receives regular income from a private pension fund, annuity, or trust

Source of Income for Adults		
Earnings from Work	**Public Assistance/Alimony/ Child Support**	**Pensions/Retirement/ All other sources of income**
• Salary, wages, cash bonuses • Net income from self-employment (farm or business) **If you are in the U.S. Military:** • Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) • Allowances for off-base housing, food, and clothing	• Unemployment benefits • Workers compensation • Supplemental Security Income (SSI) • Cash assistance from State or local government • Alimony payments • Child support payments • Veterans benefits • Strike benefits	• Social Security (including railroad retirement and black lung benefits) • Private Pensions or disability benefits • Income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • Regular cash payments from outside household

OPTIONAL Children's Ethnic and Racial Identities (Optional)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

MAIL*: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

FAX: (202) 690-7442; or
EMAIL: program.intake@usda.gov.

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***Only use this address if you are filing a complaint of discrimination.**

(revised 5/31/24)

DO NOT FILL OUT For official use only

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

Total Income _____

How often? Weekly ○ Bi-Weekly ○ Monthly ○ 2x Month ○

Household size _____

Categorial Eligibility ☐

Eligibility Free ○ Reduced ○ Denied ○

_____ Determining Official's Signature

_____ Date

_____ Confirming Official's Signature

_____ Date

_____ Follow-up Official's Signature

_____ Date

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Dr. Day Care Information

Dr. Day Care is founded by Mary Ann Shallcross Smith, Ed.D., known as "Dr. Day Care." Mary Ann began her career as an early childhood and school age professional in 1972, when she started her licensed home based day care in Lincoln, RI.

The Dr. Day Care family is comprised of the following:

- **Child Care Consultants & Facilities Management** - oversees Dr. Day Care, Kids Klub, and Therapeutic Child Care Services and ensures compliance with all regulatory agencies.

- **Dr. Day Care Learning Center** - our learning centers utilize a unique curriculum that is based on the latest research on how children learn and develop early literacy, math, comprehension, physical, and social skills. Our extraordinary administrators and educators create nurturing and secure environments where children are eager to learn in a way that's natural and fun for them. We are the Home of the Educational Guarantee!

- **Kids Klub** - a non-profit child care organization that was co-founded by Dr. Mary Ann Shallcross Smith and Dr. Karen Annotti in 1987. Originally a single location in Lincoln, RI, Kids Klub has evolved into multiple locations throughout Rhode Island. Kids Klub provides a safe, supervised environment with activities that enhance the student's environment with activities that enhance the student's physical, emotional, social, and cognitive development.

- **Therapeutic Child Care Services (TCCS)** - a service developed by the Rhode Island Department of Human Services (DHS) that provides specialized services for children and youth with special needs. This gives children and youth the opportunity to learn, play, and socialize with their friends. TCCS supports children with special needs in a mainstream setting. Through an inclusive integrated environment, TCCS offers services by trained professionals that meet the needs of all children.

Thank you for choosing to be a part of Dr. Day Care!

Connect with us:

web - www.drdaycare.com facebook - @drdaycareri instagram - @drdaycarelearningcenter

Our Mission Statement: To provide family, youth and child services in a safe, structured, and nurturing environment through a team of dedicated professionals.