

Dear Parent

Thank you for choosing Northern Children's Network Inc for your child care needs. Please find attached the 2012 Enrolment Form and for parents applying for In Home Care, the Eligibility Criteria Form.

To assist us in placing your child/ren, we ask that you fully complete the enrolment form and forward it to us with the following documentation at your earliest convenience:

- Proof of your identity – this can be a photo ID or two (2) other forms of ID which clearly state your name and address.
- Verification of your child/ren's immunisation status (if uncertain, please call the Australian Childhood Immunisation Register in Medicare Australia on 1800 653 809 or visit www.medicareaustralia.gov.au). For other questions on immunisation, call 1800 671 811.
- Copies of any custody information (where applicable).

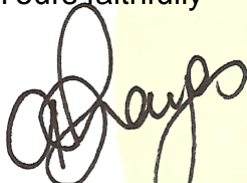
The Family Assistance Office at Centrelink is able to assist families with the cost of child care. Please contact FAO as soon as possible to register for Child Care Benefit (CCB) and Child Care Rebate (CCR). You can telephone the Family Assistance Office on 136 150 or visit www.familyassist.gov.au .

Please return the completed enrolment form with attachments relating to ID; proof of immunisation; custody arrangements (where applicable).

We will make every effort to meet your child care needs.

Please contact the office on 6341 1555 if you require any further information.

Yours faithfully

A handwritten signature in black ink, appearing to read 'Annette Hayes', written over a large, faint yellow smiley face graphic.

Annette Hayes
Administration Officer



HOME BASED CARE ENROLMENT FORM 2012



59d Amy Road, Newstead, 7250
 PO Box 724, Kings Meadows, 7249
 Phone: 6341 1555 Fax: 6344 9493
 Email: enquiries@ncn.org.au

181 Elizabeth Street, Hobart, 7000
 Phone: 6231 3414 Fax: 6231 3415
 Email: southernncs@ncn.org.au
 Web: www.ncn.org.au

Do you require an interpreter to help you with this form? Yes No

WHICH SERVICE/S DO YOU REQUIRE? (PLEASE TICK)

Family Day Care – Northern Tasmania (FDC) <input type="checkbox"/>	Southern Childcare Services (SCS) <input type="checkbox"/>
In Home Care – Northern Tasmania (IHC) <input type="checkbox"/>	

Have you used any of our services before? Yes No If yes, which service? _____

Will you also be utilising one of our Long Day Care or Outside School Hours Care services? Yes No

If Yes, which centre? _____

Are there any Family Court, Custody, Care and Protection or Restraining Orders relevant to below mentioned child/ren (If “Yes”, a copy needs to be provided to both the service and the Educator) Yes No

ENROLLING PARENT <input type="checkbox"/> GUARDIAN <input type="checkbox"/> (TICK <input checked="" type="checkbox"/>)	PARTNER
First Name: DOB: Surname: Centrelink CRN:	First Name: DOB: Surname: Centrelink CRN:

Which parent is/has enrolled for Child Care Benefit (CCB) Enrolling Parent Partner

Address: Suburb/Town/Postcode: Home phone: Mobile Phone: Email:	Address: Suburb/Town/Postcode: Home phone: Mobile Phone: Email:
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<u>RESPITE CARE</u> <input type="checkbox"/> Yes <input type="checkbox"/> No <u>WORK:</u> Full Time / Part Time / Casual / Seeking Work / Student Workplace or Place of Study: Occupation: Contact Number:	<u>RESPITE CARE</u> <input type="checkbox"/> Yes <input type="checkbox"/> No <u>WORK:</u> Full Time / Part Time / Casual / Seeking Work / Student Workplace or Place of Study: Occupation: Contact Number:
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CHILD DETAILS

Full Name (include middle name if applicable)	Sex	Date of Birth	Centrelink CRN	Medicare Number (11 digits)
1				
2				
3				
4				

CHILD/REN'S RESIDENTIAL DETAILS

Address:	Suburb:	P/code:
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EDUCATORS NAME: _____	OFFICE USE ONLY Immunisation: <input type="checkbox"/> Court Orders: <input type="checkbox"/> Proof of ID: <input type="checkbox"/>
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ADDITIONAL CARE INFORMATION

Date Care to Commence: School pickup/drop off? Yes No
 Preferred area(s) for care or preferred Educator:
 Are you a Shift Worker? Yes No Do you have rostered days off? Yes No
 If yes, please provide details/roster.

DAYS AND HOURS OF CARE REQUESTED

Permanent Booking <input type="checkbox"/>			Casual Booking <input type="checkbox"/>						
Child	Service		MON	TUES	WED	THUR	FRI	SAT	SUN
1		Start							
		Finish							
2		Start							
		Finish							
3		Start							
		Finish							
4		Start							
		Finish							

EMERGENCY CONTACTS AND AUTHORISED PEOPLE TO COLLECT (Other than parent/s. Minimum 2 contacts required)
 If you have additional contact persons, please attach a separate sheet

Name: Home Phone: Home Address: Workplace/School: Work Phone: Mobile Number: Relationship to child: <input type="checkbox"/> Contact <input type="checkbox"/> Collect	Name: Home Phone: Home Address: Workplace/School: Work Phone: Mobile Number: Relationship to child: <input type="checkbox"/> Contact <input type="checkbox"/> Collect	Name: Home Phone: Home Address: Workplace/School: Work Phone: Mobile Number: Relationship to child: <input type="checkbox"/> Contact <input type="checkbox"/> Collect	
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GENERAL INFORMATION

Child's Doctor: Phone:
 Address:
 Do you have any objections to pets? (Please detail) Yes No
 Can NCN/SCS use images of your child for promotional/media purposes? Yes No

MARKETING

For statistical purposes, could you please complete the following survey
 I/We heard about NCN/SCS and their services from:
 Word of Mouth Television Yellow Pages Radio
 Newspaper NCN Educator Other. Give details

SPECIAL/ADDITIONAL NEEDS

Does your child/ren have any medical conditions or developmental delays? Please identify and provide details:

- | | | |
|--|--|---|
| 1. Allergies:
(eg. Foods, insects, pollen) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Medication Required: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Intellectual:
(eg. Autism, Down Syndrome, Foetal Alcohol Syndrome) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Medication Required: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Physical/Sensory:
(eg. Cerebral Palsy, Cystic Fibrosis, hearing/visual impairment) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Medication Required: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Developmental Delays:
(eg. Language, muscle tone, mobility) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Medication Required: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Other Conditions:
(eg. Asthma, ADHD, other medical conditions) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Medication Required: <input type="checkbox"/> Yes <input type="checkbox"/> No |

If you answered yes to any of the questions above, please give a brief description or medical action plan.

(eg Child - Johnny Citizen, Asthma, Inhaler)

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Please list any support agencies that your child/ren are accessing (eg speech pathology, occupational therapy, physiotherapy).

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Are there any special requirements regarding culture, religion, accident, emergency, Court Orders or special needs pertaining to the child/ren which the Educator needs to be aware of? Yes No

If yes, please detail.....

.....

CHILD CARE BENEFIT (CCB) PROCESSING INFORMATION

Do you have a child attending this service who has already attended another approved child care service in the current financial year? Yes No

Do you have a child attending this service who is also attending another approved child care service? Yes No

Does the child have a sibling listed on the family's assessment notice who is attending another approved long day care service, in-home care service or specialised outside school hours care service? Yes No

Answering YES to any of the above questions may affect your child's CCB percentage or entitlement to eligible hours and allowable absence days.

To avoid an underpayment, contact our head office on (03) 6341 1555 if your usage of other child care services changes.

CENSUS INFORMATION (The following questions are used for Commonwealth Census purposes only)

ENROLLING PARENT/GUARDIAN

Country of Birth:

Aboriginal Yes No Torres Strait Islander Yes No Both Yes No

Religion:

Primary language spoken at home (if not English):

PARTNER

Country of Birth:

Aboriginal Yes No Torres Strait Islander Yes No Both Yes No

Religion:

Primary language spoken at home (if not English):

CHILD/REN

Country of Birth:

Aboriginal:

Torres Strait Islander:

Religion:

Primary language spoken at home (if not English):

School attending (if applicable):

<u>Child 1</u>	<u>Child 2</u>	<u>Child 3</u>	<u>Child 4</u>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

STATEMENT

- I agree to abide by the current conditions and policies of Northern Children’s Network Inc. (available at each service/offices).
- I agree to my child/ren being cared for and/or transported by service staff in an emergency.
- I agree to my child/ren receiving medical attention and being transported by ambulance in an emergency as recommended by the doctor, hospital, ambulance staff or paramedics.
- I understand that non work related care hours may be reduced or ‘placed on hold’ to accommodate work or study related care. This practice is in accordance with the Commonwealth Priority of Access Guidelines.
- I agree to pay the organisation’s Administration Levy every week to the Educator and understand this amount will be deducted from any Child Care Benefit payment due to the Educator on my behalf.
- I agree to complete a Parent/Educator Agreement at the commencement of care.
- I agree to a copy of the information contained on this enrolment form being forwarded to the Educator/service upon the commencement of care.
- I agree to advise NCN/SCS, the service and my Educator/s within 14 days of any change in the information provided.
- I agree that NCN/SCS may from time to time send newsletters and other relevant information electronically to my email account.
- The information that I have provided on this form is true and accurate at the time of completion.

Parent Signature:

Date:

Northern Children’s Network Inc. (NCN) is an approved child care service operator under the provisions set out in the family assistance law, and is subject to the National Privacy Principles (NPPs) under the Privacy Act in the handling of personal information. (Refer to www.facs.gov.au/childcarehandbook, www.privacy.gov.au/act/npps)

IN HOME CARE



6 MONTHLY ELIGIBILITY CRITERIA VERIFICATION

Name: _____

Address: _____

Telephone No: _____ Date: _____

Reason for Care

To be eligible to receive In Home Care children must meet at least one criteria and one category.

Criteria

In Home Care places are targeted to families who:

- have no access to existing child care services
- their circumstances mean that an existing child care service cannot meet their needs

Categories

1. The child has, or lives with another child who has, an illness or a disability
2. The child's guardian (or guardian's partner) has an illness or disability that affects their ability to care for the child
3. The child lives in a rural or remote area
4. The work hours of the child's guardian (or guardian's partner) are hours when no other approved child care service is available.
5. The child's guardian (or guardian's partner) is caring for three or more children who have not yet started school.....

Comments:

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Parent Signature:

Staff Signature:

Please notify NCN immediately if your situation changes.

This form is to be completed and returned to NCN prior to care starting or continuing.