



Maui Family Support Services, Inc.

Strengthening Children and Families in Maui County since 1980!

Quality Care for Hawaiian Keiki Subsidy Program CHILD CARE SUBSIDY ASSISTANCE REDETERMINATION APPLICATION

*Aloha QCHK 'Ohana, Your family is due for your annual redetermination of QCHK subsidy assistance. Please complete the attached application, gather the documents listed below and submit your items as listed in *STEP 3: SUBMISSION* section.*

- ***We MUST receive ALL of the items listed below by: _____.***
Failure to do so will result in loss of your childcare subsidy for your child(ren).
- *Submission of these forms DOES NOT guarantee continued assistance; you must be found eligible to continue to receive assistance.*

Criteria for Eligibility:

You must provide verification that you ***continue to meet*** the following eligibility criteria:

1. That the parent(s)/guardian(s) is/are working or attending school/training for at least 20 hours per week, OR is/are actively seeking employment or school/training enrollment;
2. That your family is under the allowable monthly gross income based on family size as shown in the Income Guideline Table below:

2 Person	3 Person	4 Person	5 Person	6 Person	7 Person	8 Person
\$4,750	\$5,867	\$6,985	\$8,103	\$9,220	\$9,430	\$9,639

3. OR, that you meet/continue to meet the criteria that exempts you from the above work/income requirements.

Redetermination Application Process:

STEP 1: Complete this application **IN FULL**. Be sure to **SIGN AND DATE** the completed application.

STEP 2: Collect all Required Documents.

STEP 3: Submit your application and documentation in one of the ways listed below.

1. Submit forms online at WWW.MFSS.ORG/RED
2. Fax the forms to us (808-868-4113)
3. By mail to QCHK 95 Mahalani St. Suite 27, Wailuku, HI 96793
4. In person to the QCHK office at 95 Mahalani St. Suite 27, Wailuku, HI 96793
(Between the hours of 8 – 3 Monday through Friday ~ please call first 808-793-2816)

STEP 4: It is **YOUR** responsibility to confirm that we have received the required forms. We recommend you call us to let us know you have submitted forms so that we can make sure we have received them:

QCHK REQUIRED DOCUMENTS CHECKLIST

YOUR APPLICATION WILL NOT BE PROCESSED UNTIL ALL DOCUMENTS ARE RECEIVED

Parent/Caregiver Name: _____ Date: _____

**** PLEASE INITIAL EACH ITEM AS YOU COMPLETE IT AND SUBMIT THIS FORM WITH YOUR APPLICATION****

REQUIRED ITEMS TO VERIFY ELIGIBILITY	PARENT INITIALS
REDETERMINATION APPLICATION - COMPLETE – SIGN – DATE	
Enrollment Confirmation Form – Completed and signed by child care provider for each child receiving QCHK assistance.	
IF APPLICABLE: Special Circumstances Form.	
Income Verifications – 2 (TWO) months of paystubs/unemployment verification; or Self Employment verification for each parent/caregiver residing in the home: Self-employment: submit evidence of income received including most recent 2 quarters of State of Hawaii, General Excise/use tax returns, copies of checks received over past 2 months, or Profit and Loss Statement reflecting last 2 months. You will be notified if additional verification is needed. Self-employed individuals must verify income of at least \$800 per month to be considered employed at least 20 hours per week.	
Bank Statements – 2 (TWO) months of bank statements for all accounts – Provide FULL bank statement, parent’s/caregivers name must be visible on the statement. You may black out account number except last four digits. Please provide all bank statements that coincide with direct deposits listed on your paystubs.	
Up-to-Date Immunization records for all children receiving assistance.	
IF APPLICABLE: Birth Certificates for any <u>NEW</u> children in the household, even if NOT requesting assistance for that child.	
IF APPLICABLE: School/Training Verification- Acceptance letter or school schedule reflecting credits/hours enrolled.	

REQUIRED ITEMS TO RE-ENROLL INTO THE QCHK PROGRAM <i>(Included with this Redetermination Application for you to review/complete)</i>	PARENT INITIALS
Review the following forms. These forms are for your information and do not need to be signed or returned: <ul style="list-style-type: none"> ➤ Family and Participant Rights ➤ Participant Grievance Process ➤ HIPAA Brochure 	
Review, complete and sign the Consent to Participate in MFSS Services – <i>THIS IS YOUR ACCEPTANCE TO PARTICIPATE IN A PROGRAM OF MAUI FAMILY SUPPORT SERVICES, INC.</i>	
Review, sign and date the Parent Agreement, <u>ACCEPTING TERMS AND CONDITIONS TO RECEIVE CHILD CARE SUBSIDY ASSISTANCE. PLEASE READ CAREFULLY!</u>	
Review, complete and sign the Consent to Release/Obtain Information - ONE FOR EACH CHILD CARE PROVIDER & CHILD CARE CONNECTION CONSENT We are requesting all families provide consent to communicate with Child Care Connection Hawaii to ensure that there are no duplication of subsidy assistance with them, which is against our funder guidelines.	
Complete the Annual School Readiness Survey	
Complete the QCHK Annual Satisfaction Survey	

COMPLETED BY QCHK STAFF:

All forms received Staff Initials/Date: _____

ASSESSMENT: #1: Staff Initials/Date: _____ #2: Staff Initials/Date: _____

DETERMINATION: Program Director Initials/Date: _____

>>>Forward ONLY WHEN APPROVED to Provider Specialist.

Provider Status: Approved Ready to Pay. Provider Specialist Initials/Date: _____

>>>Forward to Program Director ONLY when provider is confirmed/approved for payment.

ADDED TO PAYMENT LIST: Program Director Initials/Date: _____

REDETERMINATION APPLICATION

I. FAMILY UNIT INFORMATION

Please Print: (Must provide information for each parent/guardian living in the household applying for assistance).

Name: Last	First	M.I.	Marital Status	Birth Date (mm/dd/yy)	Gender
Applicant (parent/guardian):				If under 18 please provide a copy of your birth certificate	
Race/Ethnicity: ___ Hawaiian Other:					
Co-Applicant (parent/guardian):				If under 18 please provide a copy of your birth certificate	
Race/Ethnicity: ___ Hawaiian Other:					
Failure to disclose ALL household members could result in disqualification/termination of services.					
Mom, are you currently pregnant? ___ YES ___ NO			Do you need Interpretation Services? ___ YES ___ NO		
Mailing Address		City	Zip Code	Applicant Email Address:	
				Applicant Phone	
			Is this a good way to reach you? ___ YES ___ NO		
Residence Address (if different from mailing address)			Co-Applicant Email Address:		Co-Applicant Phone
			Is this a good way to reach you? ___ YES ___ NO		
HOUSING STATUS: OWN/RENT OUR OWN HOME: ___ LIVING WITH FAMILY/FRIENDS: ___					
**If one of the items below, please complete a SPECIAL CIRCUMSTANCES FORM verifying your housing status. Families living at the Shelter or who are unsheltered/houseless may receive additional consideration for child care subsidy assistance.					
LIVING IN SHELTER: ___					
HOUSELESS: LIVING IN CAR/PARK/TENT OR OTHER AREA NOT DESIGNATED FOR SLEEPING: ___					
Applicant Employment Status: (Employer/School/Job Training Program):			Circle Work/School Days Su M T W Th F Sa	Start/End Time	Hrs/Wk
Applicant 2 nd Job/Activity: (Employer/School/Job Training Program):			Circle Work/School Days Su M T W Th F Sa	Start/End Time	Hrs/Wk
Co-Applicant Employment Status: (Employer/School/Job Training Program):			Circle Work/School Days Su M T W Th F Sa	Start/End Time	Hrs/Wk
Co-Applicant 2 nd Job/Activity: (Employer/School/Job Training Program):			Circle Work/School Days Su M T W Th F Sa	Start/End Time	Hrs/Wk

INFORMATION ABOUT CHILD(REN) WHO YOU NEED SUBSIDY ASSISTANCE FOR:

Child # 1 Name: Last	First	M.I.	Age	Birth Date (mm/dd/yy)	Sex (M/F)
Race/Ethnicity: ___ Hawaiian Other:			Does your child have an identified disability or medical diagnosis? ___ Y ___ N (QCHK Verified <input type="checkbox"/>)		
Your relationship to the child?		Biological Parent	Resource Caregiver	Other Guardian	
Child Care Provider / Preschool Name:					
*PLEASE ATTACH ENROLLMENT CONFIRMATION COMPLETED BY THE LISTED CHILD CARE PROVIDER.					
Are you receiving OR have you applied for other subsidy assistance for this child? ___ Receiving ___ Applied ___ N/A					
___ Maui County Subsidy ___ Child Care Connection/Arbor ___ Preschool Open Doors ___ Pauahi Keiki Scholars					
Other:					

Child #2 Name: Last		First		M.I.	Age	Birth Date (mm/dd/yy)	Sex (M/F)
Race/Ethnicity: ___ Hawaiian Other:				Does your child have an identified disability or medical diagnosis? ___Y ___N (QCHK Verified <input type="checkbox"/>)			
Your relationship to the child? Biological Parent Resource Caregiver Other Guardian							
Child Care Provider / Preschool Name:							
*PLEASE ATTACH ENROLLMENT CONFIRMATION COMPLETED BY THE LISTED CHILD CARE PROVIDER.							
Are you receiving OR have you applied for other subsidy assistance for this child? ___ Receiving ___ Applied ___ N/A							
___ Maui County Subsidy ___ Child Care Connection/Arbor ___ Preschool Open Doors ___ Pauahi Keiki Scholars							
Other:							
Child #3 Name: Last		First		M.I.	Age	Birth Date (mm/dd/yy)	Sex (M/F)
Race/Ethnicity: ___ Hawaiian Other:				Does your child have an identified disability or medical diagnosis? ___Y ___N (QCHK Verified <input type="checkbox"/>)			
Your relationship to the child? Biological Parent Resource Caregiver Other Guardian							
Child Care Provider / Preschool Name:							
*PLEASE ATTACH ENROLLMENT CONFIRMATION COMPLETED BY THE LISTED CHILD CARE PROVIDER.							
Are you receiving OR have you applied for other subsidy assistance for this child? ___ Receiving ___ Applied ___ N/A							
___ Maui County Subsidy ___ Child Care Connection/Arbor ___ Preschool Open Doors ___ Pauahi Keiki Scholars							
Other:							

OTHER CHILDREN IN THE FAMILY UNIT: (Living in the household but NOT applying for assistance)

Name: Last	First	M.I.	Age	Birth Date (mm/dd/yy)	Sex (M/F)
Race/Ethnicity: ___ Hawaiian Other:					
Race/Ethnicity: ___ Hawaiian Other:					
Race/Ethnicity: ___ Hawaiian Other:					
Race/Ethnicity: ___ Hawaiian Other:					
Family Size (Total of members listed above)					

Are you currently participating in any other MFSS Programs? _____ Yes _____ No

If yes, which program? _____

REDETERMINATION APPLICATION

II. FINANCIAL STATEMENT OF FAMILY UNIT

Monthly Income Worksheet

Fill in amounts for types of income that apply to your family. Please submit copies of last 2 months of paystubs and applicable benefit summaries, statements etc., for other sources of income. **If self-employed:** submit verification of income received from self-employment including most recent 2 quarters State of Hawaii General Excise/Use Tax returns, copies of checks received over past 2 months and Profit and Loss Statement for business covering most recent 2 month period. You will be notified if additional documents are needed.

Gross Monthly Income from Paystubs (Applicant)	\$
Gross Monthly Income from Paystubs (Co-Applicant)	\$
Monthly Take Home /Net Income from Paystubs (Applicant)	\$
Monthly Take Home / Net Income from Paystubs (Co-Applicant)	\$
Monthly Income from Self Employment (See Instructions Above)	\$
Monthly Unemployment Benefits	\$
Total DHS Monthly Benefits: Cash Assistance \$_____ + SNAP \$_____ =	\$
Social Security Benefits	\$
Child Support / Alimony Received	\$
Government Housing Assistance (HUD)	\$
Workers Compensation	\$
TDI	\$
Pension/Retirement	\$
Veterans Benefits	\$
Child Care Financial Aid From Other Sources (COMPLETE TABLE BELOW)	\$
Rental Property Income	\$
Foster/ Adoption Assistance payment	\$
Military Allotment	\$
Other	\$
TOTAL Available Monthly Income (Add amounts in shaded areas above)	\$
WIC Participant? (Check) _____ YES _____ No	

Asset Declaration: (Provide copies of most current bank statements for all savings & checking accounts.)

Checking Account (Current Balance Total from all accounts): \$ _____

Savings Account (Current Balance Total from all accounts): \$ _____

I hereby certify that all the information contained on this form is **TRUE AND CORRECT** to the best of my knowledge. I submit this application with the understanding that I will give any additional information that may be needed and will allow QCHK, a program of Maui Family Support Services, Inc., to verify my statements either with me or through other sources as necessary. I fully understand and accept my responsibility to report changes in my situation including changes in my child's enrollment status, family income, employment status, family size, or residence within 10 days. Furthermore, **I understand that if I fail to report changes and receive services to which I am not entitled, the amount of overpayment will be collected from me, and I may be prosecuted for fraud.** I understand that services are subject to the availability of funds.

Applicant's Signature: _____ Date: _____

Co-Applicant's Signature: _____ Date: _____

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Quality Care for Hawaiian Keiki

CHILD CARE ENROLLMENT CONFIRMATION

To the Child Care Provider:

The family listed below is applying for child care assistance from Quality Care for Hawaiian Keiki (QCHK). To process their application, we need the enrollment information below. Please complete and return this enrollment confirmation to QCHK by email (QCHK@MFSS.org), or fax (868-4113), or by mail (Quality Care for Hawaiian Keiki, 95 Mahalani St., Ste. 27, Wailuku, HI 96793). We will contact you if this family becomes eligible to receive assistance from our program.

Provider's Name:	Are you Licensed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Email Address:	Phone:
Mailing Address:	
Parent/Family Name:	Email address
Child's name & birth date:	

1. Child care started on _____ Will start on _____ Services are waitlisted
 If child is starting at mid-month, is there a pro-rated amount for care? No Yes \$ _____

If your service is temporary (for summer care or intercession), what is the **service end date**? _____

2. When is child care provided: **WHAT TIME:** From _____ To _____
WHAT DAYS: Monday Tuesday Wednesday Thursday Friday Saturday Sunday

3. What is the **MONTHLY COST OF CHILD CARE (per child):** \$ _____
 Do you charge a registration / application fee? No Yes How much? \$ _____

Is other financial assistance being received for the child named above? No Yes
 If yes, how much? \$ _____ From whom? _____

4. **If you are not a licensed provider, are you related to the child** named above? No Yes
If yes, check the box below that best describes your relationship to the child named above:
 I am the Grandparent or Great Grandparent I am the Parent's sibling or spouse to parent's sibling
 I am the child's sibling or spouse to child's sibling Other relation not listed here

Provider's Signature:	Date:
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For QCHK: Date Received: _____ by _____	<input type="checkbox"/> Forwarded to Provider Specialist
This Enrollment Confirmation is <input type="checkbox"/> New <input type="checkbox"/> from a Change Request <input type="checkbox"/> for Redetermination <input type="checkbox"/> for temporary care (summer or intercession)	



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MFSS QCHK SPECIAL CIRCUMSTANCES PRIORITIZATION

Some families may be eligible for “SPECIAL CIRCUMSTANCES” PRIORITIZATION. If your family situation fits at least 1 item in Section II or III, you/your family may be eligible for Special Circumstances Prioritization. Please see each section for type of documentation/verification needed to confirm your Special Circumstance.

Completion and Submission of this form does not guarantee that you will be identified as having a “Special Circumstance” or that you will be approved for QCHK child care subsidy assistance.

SECTION I	Section I: Family/Child Information:			
	Applicant/Primary Caregiver Name:		Primary Phone Number:	
	Mailing Address:		Alternate Phone Number:	
	Residence Address if different from mailing address:			
	Co-Applicant/Primary Caregiver Name:		Primary Phone Number:	
	Mailing Address:		Alternate Phone Number:	
	Residence Address if different from mailing address:			
	NAMES OF CHILDREN YOU ARE REQUESTING QCHK ASSISTANCE FOR:			
SECTION II	Section II: APPLICANT VERIFIABLE SPECIAL CIRCUMSTANCES: <i>These items can be verified through documentation provided by the Applicant/Co-Applicant and do not need outside agency/program/services to verify.</i>			
	<input type="checkbox"/> One of the children named above has a disability or special need outside of the normal range. A			
	➤ PROVIDE COPY OF IFSP, IEP OR MEDICAL DIAGNOSIS/MEDICAL RECORDS			
	<input type="checkbox"/> A Primary Caregiver(s) is/are currently incarcerated. A			
	➤ PROVIDE DOCUMENTATION OF INCARCERATION INCLUDING START DATE OF CONFINEMENT			
	<input type="checkbox"/> One or both of the Primary Caregiver(s) named above is/are less than 18 years old. B			
	➤ PROVIDE BIRTH CERTIFICATE(S) OF PRIMARY CAREGIVER(S)			
	<input type="checkbox"/> The Primary Caregiver(s) is/are the Hanai Caregiver(s) of the child/ren named above. B			
	➤ PROVIDE COPY OF DOCUMENTS AUTHORIZING GUARDIANSHIP OF CHILD(REN)			
	<input type="checkbox"/> One or both of the child/ren’s Primary Caregiver(s) is/are legally disabled and unable to work. C			
➤ PROVIDE VERIFICATION OF DETERMINATION OF LEGAL DISABILITY				
<input type="checkbox"/> One or both of the child/ren’s Primary Caregiver(s) is/are receiving services for Intimate Partner/Family Violence. D				
➤ PROVIDE COPY OF RESTRAINING ORDER (or see behind for agency/program/service provider verification)				
<input type="checkbox"/> The Primary Caregiver(s) is/are the Resource Caregiver(s) of the child/ren named above. D				
➤ PROVIDE COPY OF RESOURCE CAREGIVER APPROVAL FROM THE DEPARTMENT OF HUMAN SERVICES, FOR THE CHILD/REN NAMED ABOVE				

Section III: Special Circumstances to be verified by an Agency/Program/Service Provider: These items MUST be verified by the agency/program/service provider listed below.

I, the applicant/co-applicant as listed in Section I, authorize the agency/program/service provider listed below to complete this form providing information about myself, my child(ren) and/or my family to the MFSS Quality Care for Hawaiian Keiki program. In addition, by signing below, I authorize the QCHK program to contact the agency/program/service for further clarification if needed.

Agency/Program/Service Provider Name:	
Name of Provider:	

Applicant Signature: _____ Date: _____

Co - Applicant Signature: _____ Date: _____

SECTION III

To be completed by the Agency/Program/Service Provider Listed above:

- The child's primary caregiver(s) is/are in substance treatment or have been discharged within the last 90 days. **D**
- The child's primary caregiver(s) has/have been released from incarceration within the last 90 days. **D**
- The child's primary caregiver(s) is/are receiving mental health support which includes: **B**
 - Receiving therapy Taking medication
- The child's family is involved with Child Welfare Services or a CWS Diversion Program (VCM, FSS, PSS, DHS-HV) or was discharged within the last 90 days. **D**
- The child's primary caregiver(s) is/are responsible to care for someone in the home who is diagnosed/confirmed with a disability (physical, developmental, emotional, or psychiatric) requiring special care or treatment that prevents/limits the primary caregiver from working. **D**
- The child's primary caregiver(s) reported to the Agency/Program/Service Provider situations of Intimate Partner/Family Violence. **D**
- The child/rens's family is houseless*. **D**
 - **MUST BE VERIFIED BY AN AGENCY/ORGANIZATION SERVING THE HOUSELESS.**
 - *Houseless-lacking a fixed, regular and adequate night time residence. Living in shelter, car, park, tent or other area not designated for sleeping.*

SECTION IV

Section IV: Signature of Agency/Program Service Provider representative.

I hereby certify that I am the providing agent/professional providing services for this child/family; and, in my professional capacity, I have determined that the child/family meet the above Special Circumstances that I have indicated.

Signature of Individual Completing this form:

 Signature Title Date

Contact Email: _____ Contact Phone: _____



Maui Family Support Services, Inc.

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KEEP FOR YOUR RECORDS

Family & Participant Rights

To be used with Notification of Family Rights, Grievance Process; and Privacy Practices

Maui Family Support Services, Inc. shall ensure the protection of families'/participant's rights in accordance with Federal and State regulations and Maui Family Support Services Policies. A Maui Family Support Services, Inc. employee has explained, and I understand, the following statements:

- The right of access to a qualified advocate in order to understand exercise and protect your rights.
- The right to file a complaint/grievance with respect to infringement of these rights, including the right to have such grievances considered in a fair, timely, and impartial manner.
- The right to be informed promptly, in appropriate language that you can understand, of your rights described in this section.
- The right to a humane service setting that affords reasonable protection from harm, appropriate privacy, and is most convenient for you.
- The right to services under conditions that are free from unlawful discrimination and support your personal liberty. Such liberty will be restricted only as necessary to comply with the law, and judicial orders.
- The right to be provided with a reasonable explanation of all aspects of your services.
- The right to confidentiality of records except when staff are mandated by law to report suspected dependent adult abuse, child abuse and/or neglect; when handling any legal proceedings or when conditions of emergency occur and/or there are threats of homicide or suicide.
- I understand that funding requirements of MFSS programs that I am involved in may require sharing of aggregated service information to such funders, evaluators or researchers. I understand that information provided to these funding sources, evaluators or researchers is generally provided in an aggregated format and specific details on myself or my family are not provided in these reports. This information will generally be shared via monthly, quarterly or yearly reports as requested by said funders.
- The right to have access to your record upon request and in accordance with MFSS policy and procedures.
- The right to submit a written request to change or supplement any portions of your record, that you feel are not accurate, relevant, or complete, according to MFSS policy and procedures.
- The right to select a provider agency and to receive a MFSS referral to another provider agency.
- The right to exercise your rights described in this section without any negative effect on your services and/or treatment
- The right to approve or deny any release of or obtaining of information regarding myself or my family. I have been given an opportunity to review and sign both the Consent to Release and Consent to Obtain and have chosen who I do and do not want MFSS to release to or obtain information from.
- The right to refuse service and to be informed of the possible consequences of such refusal.

Your Participant Rights Advisor is:

Zina Andrade - Administrative Supervisor, (808) 242-0900 ext. 222

FAMILY AND PARTICIPANT RIGHTS UPDATED 11.2020 DL

**Administrative Office
& Kupukupu
Child Development Center:**
1844 Wili Pa Loop
Wailuku, HI 96793
Phone: (808) 242-0900
Fax: (808)249-2800

**Quality Care for
Hawaiian Keiki:**
95 Mahalani St. Ste 27
Wailuku, HI 96793
Phone: (808)793-2816
Fax: (808) 868-4113

**EHS Child Development Center:
LAHAINA**
15 Ipu Aumakua Lane
Lahaina, HI 96761
Phone: (808) 661-1170
Fax: (808) 661-1198

**EHS Child Development Center:
WAIALE**
67 Waiale Rd
Wailuku, HI 96793
Phone: (808) 242-7849

**Hale Hi'ipoi
Hana Infant and
Toddler Center:**
4111 Hana Hwy
P.O. Box 938
Hana, HI 96713
Phone: (808)248-7609

**Maui County
Early Childhood
Resource Center:**
2099 Wells Street
Wailuku, HI 96793
Phone: (808) 242-1608
Fax: (808) 270-5556

Moloka'i Office:
107 B Ala Malama Ave
P.O. Box 1658
Kaunakakai, HI 96748
Phone: (808) 553-8114
Fax: (808) 553-8115

Lana'i Office:
730 Lana'i Ave #109
P.O. Box 631043
Lanai City, HI 96763
Phone: (808) 565-7484





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KEEP FOR YOUR RECORDS

Participant Grievance Process

Administrative Office

& Kupukupu

Child Development Center:

1844 Wili Pa Loop

Wailuku, HI 96793

Phone: (808) 242-0900

Fax: (808) 249-2800

Quality Care for

Hawaiian Keiki:

95 Mahalani St. Ste 27

Wailuku, HI 96793

Phone: (808) 793-2816

Fax: (808) 868-4113

EHS Child Development Center:

LAHAINA

15 Ipu Aumakua Lane

Lahaina, HI 96761

Phone: (808) 661-1170

Fax: (808) 661-1198

EHS Child Development Center:

WAIALE

67 Waiale Rd

Wailuku, HI 96793

Phone: (808) 242-7849

Hale Hi'ipoi

Hana Infant and

Toddler Center:

4111 Hana Hwy

P.O. Box 938

Hana, HI 96713

Phone: (808) 248-7609

Maui County

Early Childhood

Resource Center:

2099 Wells Street

Wailuku, HI 96793

Phone: (808) 242-1608

Fax: (808) 270-5556

Moloka'i Office:

107 B Ala Malama Ave

P.O. Box 1658

Kaunakakai, HI 96748

Phone: (808) 553-8114

Fax: (808) 553-8115

Lana'i Office:

730 Lana'i Ave #109

P.O. Box 631043

Lana'i City, HI 96763

Phone: (808) 565-7484

If any questions or concerns arise during the delivery of services, please share your concerns with our agency. Below is the process for sharing your concerns:

- A. Please share your concerns with your home visitor, child's teacher, or group facilitator. They will work with you to find a resolution
- B. If you have addressed your concerns with one of the above and/or do not feel comfortable addressing your concerns with them, please contact their immediate supervisor.
- C. If you have not been successful in resolving your concerns with his/her supervisor, please contact the Participants Rights Advisor listed below.
- D. You may be asked to put your concerns in writing, or recording. You may ask for help in doing so if needed.
- E. Within five working days of receiving the written or recorded grievance, the Participant Rights Advisor shall contact you to discuss the grievance. All efforts will be made to reach a mutually satisfactory resolution and the resolution will be documented. If a satisfactory resolution can be identified and implemented, no further action will be taken. If not, the following steps shall be taken.
- F. The Participant Rights Advisor will appoint two mediators (staff members who have not been connected with your family previously) to meet with you and review the information.
- G. During this meeting you have the right to bring to the meeting any relevant person who can shed light on, or support your concerns.
- H. Within the next five working days, the mediators shall review all relevant materials and set up any further interviews with you.
- I. Within 30 days of the meeting, the mediators shall forward a written report to the Participant Rights Advisor, with a summary of the grievance and their recommendations.
- J. Within five working days of receiving the report from the mediators, the Participant Rights Advisor shall:
 1. Review the information with the CEO.
 2. After studying all the relevant material in conjunction with the mediator's report, the CEO and Participant Rights Advisor will come to a final decision about the grievance.
 3. The Participant Rights Advisor will meet with you to inform you of the decision and work with you to plan for future services including any further appeal, right, or recourse.

Participant Rights Advisor: Zina Andrade 808-242-0900

PARTICIPANT GRIEVANCE PROCESS REVISED 11.2020 DL





Maui Family Support Services is committed to protecting your health information. This notice describes how health information about you may be used or disclosed, and how you can get access to this information. It explains your rights to privacy of your health information as required by the 1996 Healthy Insurance Portability and Accountability ACT (HIPAA).

Understanding Your Health Information

Each time a Family Facilitator from Maui Family Support Services (MFSS) visits you, a record of this visit is made. This record contains information you provide about your health, past and current family information, social, economic, educational and other information. It also contains child developmental screens and results, immunization and health care provider information, medical insurance coverage, and an Individual Family Support Plan (IFSP)/Family Partnership Agreement (FPA) for ongoing services. This record serves as:



- A plan for how to best serve your family;
- A way of measuring progress of family goals;
- A way for the many professionals who service you and your family to work together for smooth service delivery;
- Legal document describing the service you received;
- A tool which we can use to improve the services we provide and the outcomes we achieve with you;
- A source of information for public health officials charged with improving the health of the nation; and
- A way you or MedQUEST can verify that services billed were actually provided for infants and toddlers with special needs or for children receiving medically fragile case management services from public health nursing.

O:\WP51\EH\SF\FORMS\2014\Brochure Notice of Privacy Practices

- Provide you with notice as to our legal duties and privacy practices related to information we collect and maintain about you;
- Follow the terms of this notice;
- Tell you if we are unable to agree to your requested written restriction as to the use or disclosure of your health information; and
- Allow reasonable requests you make to share information by different means or different places.

Maui Family Support Services has the right to change our *Notice of Privacy Practice* and to make new rules for all the protected health information we keep. Should our rules change, we will mail a notice to the address you have given us.

With your authorization, we will share and/or use health and service information:

- To verify MedQUEST/Medicaid enrollment.
- With your pediatrician, well-baby clinic, and/or chosen hospital/medical facility on child health, safety, nutrition and immunizations for your child(ren).
- With the Department of Human Services (DHS) based on needs of your family, and for program evaluation.
- With Women, Infant, and Children (WIC) based on needs of your family.
- On medically fragile children with DOH Public Health Nurses for coordination of services.
- With DOH Early Identification Services for coordination of services involving developmentally delayed children.
- With Imua Rehab based on needs of your child(ren)s growth and development.
- Required for moving from one Healthy Start/Early Head Start site/agency to another.



O:\WP51\EH\SF\FORMS\2014\Brochure Notice of Privacy Practices



Understanding what is in your record and how your information is used helps you to:

Make sure it is correct; better understand who, what, when, where and why others may access your health information, and make better decisions about sharing your information with others.

KEEP FOR YOUR RECORDS

You Have the Right to:

- Set limits on the uses of your information or determine who can look at your information;
- Ask for and receive a paper copy of this Notice;
- Ask to look over and copy your record;
- Ask, in writing, to change your record saying the reason for the change, or to add information (Original documents may not be erased);
- Ask for a listing of allowed sharing of your information, except for routine purposes of treatment, payment, operations and disclosures required by law;
- Ask that your information be shared with you in a different way or at a different place; and,
- Change your mind about allowing use or sharing of your information except to the extent that action has already been taken.



Maui Family Support Services will:

- Maintain the privacy of your information.
- Provide you with this *Notice of Privacy Practice* information in your native language if necessary.

HIPAA Compliance
 Effective 04/14/03

- With Baby S.A.F.E. based on needs of your family and community referrals.
- For regular service operations, service improvement and continuous quality improvement.

Other Uses or Disclosures:

- Notification: Maui Family Support Services may use or disclose information about your location and general condition to notify or assist in notifying a family member, personal representative, or another person responsible for your care.
- Communication with Family: Agency staff may disclose to those you identified in your consent to release information form.
- Research: We may disclose health information to researchers upon review and approval from the Institutional Review Board, with established protocols to ensure the privacy of your information.
- Public Health: As required by law, we may disclose your health information to public health authorities charged with preventing or controlling disease, injury, or disability.
- Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a court order and/or valid subpoena.

For More Information or to Report a Problem:

There are no repercussions for asking for additional information or filing a complaint.

If you believe that your privacy rights have been violated, you can file a complaint with the Director of Program Services, Maui Family Support Services 1844 Wili Pa Loop #200 Wailuku Hawaii 96793 Phone: 242-0900 OR Secretary of Health and Human Services, Hubert H. Humphrey Building 200 Independence Avenue S.W. Washington DC 20201

HIPAA Compliance
 Effective 04/14/03

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Maui Family Support Services, Inc.

Strengthening Children and Families in Maui County since 1980!

Consent to Participate in MFSS Services Notification of Family Rights, Grievance Process and Privacy Practices

To be signed when provided with Family and Participant Rights,
Grievance Procedure; and HIPAA Brochure

**Administrative Office
& Kupukupu
Child Development Center:**
1844 Wili Pa Loop
Wailuku, HI 96793
Phone: (808) 242-0900
Fax: (808)249-2800

**Quality Care for
Hawaiian Keiki:**
95 Mahalani St. Ste 27
Wailuku, HI 96793
Phone: (808)793-2816
Fax: (808) 868-4113

**EHS Child Development Center:
LAHAINA**
15 Ipu Aumakua Lane
Lahaina, HI 96761
Phone: (808) 661-1170
Fax: (808) 661-1198

**EHS Child Development Center:
WAIALE**
67 Waiale Rd
Wailuku, HI 96793
Phone: (808) 242-7849

**Hale Hi'ipoi
Hana Infant and
Toddler Center:**
4111 Hana Hwy
P.O. Box 938
Hana, HI 96713
Phone: (808)248-7609

**Maui County
Early Childhood
Resource Center:**
2099 Wells Street
Wailuku, HI 96793
Phone: (808) 242-1608
Fax: (808) 270-5556

Moloka'i Office:
107 B Ala Malama Ave
P.O. Box 1658
Kaunakakai, HI 96748
Phone: (808) 553-8114
Fax: (808) 553-8115

Lana'i Office:
730 Lana'i Ave #109
P.O. Box 631043
Lanai City, HI 96763
Phone: (808) 565-7484

I/We _____ am/are interested in receiving services from Maui Family Support Services, Inc. I/We understand that participation in any Maui Family Support Services program is voluntary.

By signing this form I/we verify that a MFSS Staff Person has provided me/us with the Family Rights Document, Grievance Process; and HIPAA Brochure and that I/we have read them and/or have had my/our rights explained to me/us in a language that I/we can understand.

I/We understand that my/our signature(s) indicate that I/we understand my/our rights as a participant in Maui Family Support Services program(s). I/We understand that my/our consent will expire when services are terminated or when I/we withdraw from services and that my/our consent can be withdrawn at any time by notification to program staff. I/We received a copy of these rights and understand that should I/we have any concerns I/we can contact the Participant Rights Advisor at 808-242-0900.

_____	_____	_____
Participant Name	Participant Signature	Date
_____	_____	_____
Participant Name	Participant Signature	Date
_____	_____	_____
Witnessed By	Witness Signature	Date

CONSENT TO PARTICIPATE IN MFSS SERVICES REVISED 11.2020 DL





Maui Family Support Services, Inc.

Strengthening Children and Families in Maui County since 1980!

Quality Care for Hawaiian Keiki

Child Care Subsidy Program Parent/Guardian Agreement Form

1. I/we understand that the Quality Care for Hawaiian Keiki (QCHK) Child Care Subsidy Program will provide assistance for childcare while I/we work or attend school/training for at least 20 hours per week.
2. I/we understand that if one or both of us are not working or in school for at least 20 hours per week at the time of this agreement, I/we will sign a provisional agreement given as a deadline to find/start work/school/training. We understand that failing to meet this deadline may result in loss of assistance.
3. I/we understand that the amount of assistance will be provided as specified in the Determination Notice.
4. I/we understand that I/we am/are responsible for any remaining balance (identified as the Parent Portion/Copay) of the monthly tuition payment, and understand that all subsidy payments are made by check from Maui Family Support Services, Inc. directly to the child care provider.
5. I/we will notify the QCHK program immediately should there be any changes in my/our hours, wages, or place of employment or school. I/we will complete the Change Request form and provide requested documentation.
6. I/we agree to have my/our child attend the designated child care as identified in my/our application. I/we understand that attendance will be monitored and if my/our child's attendance becomes irregular at any time, assistance from the QCHK program may end. I/we will notify QCHK of changes to attendance and complete the Change Request form if there is a change to my child's care schedule.
7. I/we will inform QCHK if I/we make any changes in my/our child's care (such as change of provider or change in days or hours of attendance), **AT LEAST 30 DAYS PRIOR TO SUCH CHANGE**. I/we understand that last minute changes may not be accommodated.
8. I/we will inform my provider **30 DAYS BEFORE REMOVING THE CHILD FROM THEIR CARE**. I/we understand that if I/we fail to provide my/our current provider with 30 day notice QCHK may still make a payment to them and payment to my/our new provider may be delayed.
9. I/we have reported to QCHK any funds I/we currently receive from other child care subsidy programs. I/we agree to inform QCHK of any changes in the amount of assistance received from other programs and to do my/our part to keep my/our case active with these programs as long as I/we am/are eligible.
10. I/we understand that I/we cannot have QCHK and Child Care Connection or Preschool Open Doors subsidy assistance.
11. I/we understand that if another subsidy program pays more than 70% of my/our child care costs, I/we will no longer be eligible for QCHK.
12. I/we understand that I/we am required to participate in two workshops per year provided or approved by the QCHK program.
13. I/we agree to complete, per month, 2 In-Kind (volunteer) Hours at my/our child's preschool, child care provider or other early childhood program and/or Parent Child Activity hours which will be tracked on the monthly calendar provided by QCHK and given to my provider each month.

Parent/Guardian Name(s) (Print): _____

Parent Signature(s): _____ Date: _____

QCHK Staff Signature: _____ Date: _____

REVISED 11.5.2020 DL

Revised 7/2020 DL





Maui Family Support Services, Inc.

Strengthening Children and Families in Maui County since 1980!

PARTICIPANT CONSENT TO OBTAIN AND RELEASE CONFIDENTIAL INFORMATION

I/We, _____, the _____
(Name of Participant, Parent or Legal Guardian) (Relationship)

of (NAME OF CHILD/REN & DOB) authorize
(Name of Dependent, Parent or Legal Guardian / DOB)

Maui Family Support Services, Inc, 1844 Wili Pa Loop, Wailuku, HI 96793 to **obtain/release** information acquired on our family
from/to: (NAME OF PROVIDER)
(Name/Organization/Address/Phone Number)

I/We also grant permission to: (NAME OF PROVIDER)
(Name/Organization/Address/Phone Number)

to disclose information to the **STAFF & PROGRAMS** of Maui Family Support Services, Inc., 1844 Wili Pa Loop Wailuku, HI 96793

This authorization is limited to specifically obtaining the following information:

INFORMATION PERTAINING TO QCHK CHILD CARE SUBSIDY SERVICES FOR THE ABOVE NAMED CHILDREN

Such disclosure of information is required for the following purpose(s):

INFORMATION PERTAINING TO QCHK CHILD CARE SUBSIDY SERVICES FOR THE ABOVE NAMED CHILDREN

Unless earlier revoked, this consent shall terminate on: one (1) year from date signed
(Date or condition upon which consent expires)

All information obtained by Maui Family Support Services will remain confidential. **I/We have been advised and understand that Maui Family Support Services is a mandated reporter for Child Abuse and Neglect and Dependent Adult Abuse.** Information will be shared with Maui Family Support Services, Inc. staff, on a need to know basis.

I/We acknowledge that a copy of this signed consent form is available upon request.

The purpose of this form is to coordinate and facilitate service planning for the above named Participant. I understand that my records are protected under federal and state regulations governing confidentiality and may not be disclosed without my written consent. This consent is to remain in effect until withdrawn at my/our request, or for one year from this date, whichever comes first. It can be withdrawn by me/us at any time.

(Signature of Participant, Parent or Legal Guardian) Date

(Signature of Participant, Parent or Legal Guardian) Date

(Witness/Employee's Signature) Date





Maui Family Support Services, Inc.

Strengthening Children and Families in Maui County since 1980!

ALL FAMILIES ARE ASKED TO PROVIDE CONSENT TO COMMUNICATE WITH CHILD CARE CONNECTION HAWAII TO AVOID OVERPAYMENT OF SUBSIDY ASSISTANCE.

PARTICIPANT CONSENT TO OBTAIN AND RELEASE CONFIDENTIAL INFORMATION

I/We, _____, the _____
(Name of Participant, Parent or Legal Guardian) (Relationship)

of (NAME OF CHILD/REN & DOB) _____ authorize
(Name of Dependent, Parent or Legal Guardian / DOB)

Maui Family Support Services, Inc, 1844 Wili Pa Loop, Wailuku, HI 96793 to obtain/release information acquired on our family
from/to: **CHILD CARE CONNECTION HAWAII** _____ (Name/Organization/
Address/Phone Number)

I/We also grant permission to: **CHILD CARE CONNECTION HAWAII** _____ (Name/Organization/
Address/Phone Number)

to disclose information to the **STAFF & PROGRAMS** of Maui Family Support Services, Inc., 1844 Wili Pa Loop Wailuku, HI 96793

This authorization is limited to specifically obtaining the following information:

INFORMATION PERTAINING TO CHILD CARE SUBSIDY SERVICES FOR THE ABOVE NAMED CHILDREN

Such disclosure of information is required for the following purpose(s):

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(Signature of Participant, Parent or Legal Guardian) Date

(Signature of Participant, Parent or Legal Guardian) Date

(Witness/Employee's Signature) Date





Maui Family Support Services, Inc.

Strengthening Children and Families in Maui County since 1980!

ANNUAL School Readiness - Parent Survey COMPLETE AT ANNUAL REDETERMINATION

Parent/Guardian Name: _____ Today's Date: _____

PLEASE ANSWER THE QUESTIONS FOR EACH CHILD THAT WILL BE RECEIVING QCHK SUBSIDY ASSISTANCE

Child's Name: _____ Child's Birthdate: _____

For school-aged children: <input type="checkbox"/> My child is attending school (grade _____) <input type="checkbox"/> My child has an IEP or 504 Plan with DOE.				
For Infants (under 12 months old; Check each box that applies:				
<input type="checkbox"/> Baby babbles, gurgles, makes sounds as if talking to me.	<input type="checkbox"/> Baby is starting to reach, grab, and hold items.			
<input type="checkbox"/> Well Baby-Visits are up to date.	<input type="checkbox"/> Baby smiles and makes eye contact with me.			
For children 1 to 5 years old: Do you think your child is developmentally on target in the areas of:				
Talking and Learning	<input type="checkbox"/> Mostly yes.	<input type="checkbox"/> Somewhat, yes	<input type="checkbox"/> I'm not sure	<input type="checkbox"/> My child has an <input type="checkbox"/> IFSP / <input type="checkbox"/> IEP
Health and Physical Well Being	<input type="checkbox"/> Mostly yes.	<input type="checkbox"/> Somewhat, yes	<input type="checkbox"/> I'm not sure	<input type="checkbox"/> My child has an <input type="checkbox"/> IFSP / <input type="checkbox"/> IEP
Social/Emotional Preparation	<input type="checkbox"/> Mostly yes.	<input type="checkbox"/> Somewhat, yes	<input type="checkbox"/> I'm not sure	<input type="checkbox"/> My child has an <input type="checkbox"/> IFSP / <input type="checkbox"/> IEP

Child's Name: _____ Child's Birthdate: _____

For school-aged children: <input type="checkbox"/> My child is attending school (grade _____) <input type="checkbox"/> My child has an IEP or 504 Plan with DOE.				
For Infants (under 12 months old; Check each box that applies:				
<input type="checkbox"/> Baby babbles, gurgles, makes sounds as if talking to me.	<input type="checkbox"/> Baby is starting to reach, grab, and hold items.			
<input type="checkbox"/> Well Baby-Visits are up to date.	<input type="checkbox"/> Baby smiles and makes eye contact with me.			
For children 1 to 5 years old: Do you think your child is developmentally on target in the areas of:				
Talking and Learning	<input type="checkbox"/> Mostly yes.	<input type="checkbox"/> Somewhat, yes	<input type="checkbox"/> I'm not sure	<input type="checkbox"/> My child has an <input type="checkbox"/> IFSP / <input type="checkbox"/> IEP
Health and Physical Well Being	<input type="checkbox"/> Mostly yes.	<input type="checkbox"/> Somewhat, yes	<input type="checkbox"/> I'm not sure	<input type="checkbox"/> My child has an <input type="checkbox"/> IFSP / <input type="checkbox"/> IEP
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Not sure what your baby/child should be doing? See next page for General Developmental Skill Sets.





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Child's Name: _____ Child's Birthdate: _____

For school-aged children: <input type="checkbox"/> My child is attending school (grade _____) <input type="checkbox"/> My child has an IEP or 504 Plan with DOE.	
For Infants (under 12 months old; Check each box that applies:	
<input type="checkbox"/> Baby babbles, gurgles, makes sounds as if talking to me.	<input type="checkbox"/> Baby is starting to reach, grab, and hold items.
<input type="checkbox"/> Well Baby-Visits are up to date.	<input type="checkbox"/> Baby smiles and makes eye contact with me.
For children 1 to 5 years old: Do you think your child is developmentally on target in the areas of:	
Talking and Learning	<input type="checkbox"/> Mostly yes. <input type="checkbox"/> Somewhat, yes <input type="checkbox"/> I'm not sure <input type="checkbox"/> My child has an <input type="checkbox"/> IFSP / <input type="checkbox"/> IEP
Health and Physical Well Being	<input type="checkbox"/> Mostly yes. <input type="checkbox"/> Somewhat, yes <input type="checkbox"/> I'm not sure <input type="checkbox"/> My child has an <input type="checkbox"/> IFSP / <input type="checkbox"/> IEP
Social/Emotional Preparation	<input type="checkbox"/> Mostly yes. <input type="checkbox"/> Somewhat, yes <input type="checkbox"/> I'm not sure <input type="checkbox"/> My child has an <input type="checkbox"/> IFSP / <input type="checkbox"/> IEP

General Developmental Skill Sets

Talking and Learning		Health and Physical Well Being		Social and Emotional Preparation	
12-26 months	<ul style="list-style-type: none"> Imitates speech. Starting to combine 2 or more words that are somewhat intelligible. Points to; and may name 1 or 2 objects in a picture book (not always correctly and not always clearly) Follows simple 1 to 2 step instructions More efficient and coordinated with using his/her hands when playing with and exploring objects or toys 	12-26 months	<ul style="list-style-type: none"> Walks independently, stands alone steadily, sits in a chair, throws a ball, kicks a ball, dances to music, and attempts to run fast. Uses a spoon, can drink from a cup Will mimic doing activities like wiping up a spill, sweeping, combing hair, brushing teeth. Scribbles with a crayon and begins to draw lines. Builds tower of 2 blocks. Pours and dumps things out. 	12-26 months	<ul style="list-style-type: none"> Usually friendly toward others; less wary of strangers Helps pick up and put away toys Plays alone for short periods Enjoys other children, but does not play cooperatively May have tantrums when things go wrong or if tired or hungry Asserts independence, often refuses to cooperate in routines, getting dressed. Wants to do things without help.
27-39 months	<ul style="list-style-type: none"> Makes 2 to 4 word sentences Follows 2-3 step commands Answers "yes" or "no" correctly Uses his/her first and last name Can place objects on, under, behind, and in front of Recognizes and names primary colors and basic shapes Differentiates boys and girls 	27-39 months	<ul style="list-style-type: none"> Jumps in place, peddles or foot-powers a trike, walks up steps holding on, catches a ball with stiff arms. Builds a tower of 6-10 blocks, strings beads, holds a crayon/marker like an adult, can make small snips on paper with scissors. Washes and dries own hands, starting to dress self, beginning to do daytime toileting, can feed self. 	27-39 months	<ul style="list-style-type: none"> Shows affection toward younger children May continue to have a special comfort toy Understands taking turn but not always willing to do so Friendly. Laughs frequently. Is eager to please Often talks to self Defends toys/possessions. May be aggressive at times Mostly plays alone, but will occasionally and briefly will join other children in play.
40-62 months	<ul style="list-style-type: none"> Makes 5 to 7 word sentences Is easily understood when speaking Can sit and listen to a story for 10 minutes Recites or sings familiar songs or rhymes Uses plurals, past tense, and possessives (mine, hers, baby's) Talks about events, people, and objects Identifies and names up to 8 colors 	40-62 months	<ul style="list-style-type: none"> Peddles a trike with speed & accuracy, catches a bounced ball, tries to jump rope, distance & accuracy with throwing a ball. Bathes independently, toilets independently with a few accidents, Colors mostly within the lines, can trace simple shapes (+ O □ L), cuts on a line (not perfectly), can sometimes copy the letters of his/her name 	40-62 months	<ul style="list-style-type: none"> Has fewer tantrums Enjoys pretend, make believe activities Takes turns and plays cooperatively Recognizes others have feelings Still afraid of the dark, of strangers, and of the unknown Establishes friendships Takes pride in accomplishments





Maui Family Support Services, Inc.

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QCHK ANNUAL SATISFACTION SURVEY

PLEASE SHARE YOUR FEEDBACK ON HOW THE QCHK PROGRAM SERVED YOU IN THE LAST YEAR AND WAYS WE CAN IMPROVE OUR SERVICES TO YOU.

1. Has the QCHK program helped you in being able to work or attend school/training?

- Yes, I was able to work or go to school/training because of the QCHK program's assistance.
- No, I do not feel that the QCHK program helped me to work or go to school/training.

2. Have you completed any schooling or job training in the time that you have been receiving QCHK assistance for child care?

- Yes, I have completed MY degree or certification (please list the type of degree/certification below),
- I am currently enrolled in school/job training.
- I have not been able to complete my degree as planned.
- Not Applicable.

Please share what type of degree/certificate you achieved.

3. Do you feel that we allowed you to have a choice in the provider that you selected? Yes No

4. Do you feel that you were able to access quality childcare that is comparable to childcare received by families who have higher income/more resources?

- I believe the quality of child care my child(ren) received is comparable to what other families with more income would get.
- I believe that the quality of child care my child(ren) received is not as good as what other families with more income would get.

5. Have you been able to incorporate the activities from the Monthly In-Kind Calendar into your family activities?

- Yes No

6. Have the QCHK staff provided you with information on other resources in the community that can help your family?

- Yes No





Maui Family Support Services, Inc.

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7. Please share how you have incorporated the Hawaiian Culture into your household/family.

8. Overall, how satisfied are you with the QCHK services you have received?

- Very Satisfied
- Satisfied
- Dissatisfied
- Very Dissatisfied

9. How likely are you to recommend the QCHK program to another family?

- I would definitely recommend the program to another family.
- I would not recommend the program to another family.

10. How has Covid-19 affected your family? Check all that apply.

- Job Loss
- Reduction in hours
- Unable to pay rent/utilities
- Loss of childcare
- Unable to pay child care costs
- Staying home has been very stressful
- No/very little impact from Covid-19

Please share if there are other ways that Covid-19 has affected your family.

11. Do you have any other thoughts, suggestions or feedback that we can use to make our program better?

