

INDEPENDENT CONTRACTOR FORM

- I. Independent Contractor/Early Childhood Program Provider
 - A. Program Provider and Summit County Child Care Resource and Referral Agency, Inc., D.B.A. Early Childhood Options, shall be and act as independent contractors, and under no circumstances shall this agreement be construed as one of partnership, agency, joint venture or employment between contractor and Early Childhood Options. Each party acknowledges and agrees that it neither has nor will give the appearance or impression of possessing any legal authority to bind or commit the other party in any way.
 - B. Program Provider, as an independent contractor, understands and agrees he/she is obligated to pay all federal and state income tax on all money earned pursuant to this agreement.
 - C. Both parties, understanding and acknowledging the independent contractor relationship defined herein, agree to maintain distinctly separate operations as set forth herein.
 - D. Program Provider acknowledges and agrees that he/she is not entitled to worker's compensation or professional liability benefits from Early Childhood Options pursuant to Program Provider's independent contractor relationship with Early Childhood Options as defined herein.

- II. Indemnification
 - A. Program Provider shall indemnify and hold harmless Early Childhood Options, its affiliates, officers, directors, employees, representatives, agents and/or contractors from any and all liabilities, causes of action, claims and/or demands including, but not limited to those made by third parties, which arise out of contractor's negligent acts or omissions in connection with contractor. Program Provider shall assume any and all liability for any damages arising out of its operations.
 - B. Early Childhood Options shall indemnify and hold harmless Program Provider from any and all causes of action which arise out of Early Childhood Options' negligent acts or omissions in connection with Early Childhood Options. Early Childhood Options shall assume any and all liability for any damages arising out of its operations.

Program Provider's Name (printed) Signature Date

Early Childhood Options Representative/Title Signature Date

INDEPENDENT CONTRACTOR FORM

Program Provider's Name:	Social Security Number/EIN:
Address:	Phone: Fax: E-Mail:

SUMMIT COUNTY CHILD CARE RESOURCE AND REFERRAL AGENCY, INC, D.B.A. EARLY CHILDHOOD OPTIONS	FEIN: 84-1172882
PO Box 3355 Dillon, CO 80435	Phone: 970-513-1170 Fax: 970-468-7923

Date of Service(s): _____
Payment Amount: _____
Terms: _____
Description of Services:

Early Childhood Options Summit County Early/Head Start

Confidentiality Policy:

Staff members, volunteers and parents working in any program in the Summit County Head Start Program will maintain confidentiality and respect each family's right to privacy, refraining from disclosure of confidential information and intrusion into family life. Confidential information may include but is not limited to: phone numbers, social security numbers, legal status, civil status, address, financial situation, outcome of assessments, and medical conditions.

*Except in cases of abuse or neglect, staff will disclose no information on any child or family without a signed release of confidentiality. All requests for information must be in writing and can be honored only when parents have signed a release.

Certification

I understand that during my involvement with Summit County Head Start, I may come into contact with confidential information. This information may be in regards to the program, families, staff and others. As a staff member, volunteer or parent working with the Head Start Program, I will maintain confidentiality and will respect each person's right to privacy, refraining from disclosure of confidential information and intrusion into family life.*

I, _____, certify that I have read, and do understand the above policy on confidentiality. I am willing to carry out these responsibilities. According to State Law, a person violating this policy may be liable for slander or unlawful disclosure of information.

Signed _____ Date _____

Witnessed by: (Print Name) _____

Witness' Signature: _____ Date _____



Summit County Head Start

Summit County Head Start Criminal Record Check Verification

According to the Head Start Act as amended December 12, 2007 before a Head Start agency employs an individual, such agency shall obtain a criminal record check.

This form verifies that _____ has:

___ A criminal record check on file with Summit County Head Start

___ A criminal record check on file with the Summit School District

___ A criminal record check on file with a local community agency

Which Local Community Agency? _____

By signing this document I authorize Summit County Head Start to review the criminal background check information supplied by the above agency.

Employee Signature

Date

SCHS staff Signature

Date

**Summit County Head Start
330 Fiedler Ave. Suite 209
P.O. Box 497
Dillon, CO 80435
970-513-1170
Fax 970-468-7923**



AFFIDAVIT - RESTRICTIONS ON PUBLIC BENEFITS

I, _____, swear or affirm under penalty of perjury under the laws of the State of Colorado that (check one):

- I am a United States citizen.
- I am not a United States citizen but I am a Permanent Resident of the United States.
- I am not a United States citizen but I am lawfully present in the United States pursuant to Federal law.
- I am a foreign national not physically present in the United States.

I understand that this sworn statement is required by law because I have applied for a public benefit. I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this public benefit. I further acknowledge that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal laws of Colorado as perjury in the second degree under Colorado Revised Statute 18-8-503 and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.

Signature

Date