Tax ID 31-0537178

For Youth Development
For Healthy Living
For Social Responsibility

# Tuition/Fees SACC

**Fee:** **$30 per child / $50 maximum per family**
**$15 per child / $30 maximum per families receiving assistance**
**$25 North Dearborn, IN**

| SCHOOLS: | PLEASANT RUN, STRUBLE, OLG, THREE RIVERS (PM ONLY) |
|---|---|
| FULL TIME | AM only: $30/Week<br>PM only: $55/Week<br>Both: $82/Week |
| PART TIME | AM only: $21/Week<br>PM only: $39/Week<br>Both: $58/Week |

| SCHOOLS: | COLERAIN, MONTFORT HEIGHTS, TAYLOR, |
|---|---|
| FULL TIME | AM only: $38/week<br>PM only: $47/week<br>Both: $82/week |
| PART TIME | AM only: $28/week<br>PM only: $32/week<br>Both: $58/week |

| SCHOOLS: | ST JOHNS |
|---|---|
| FULL TIME | AM only: $35/week<br>PM only: $45/week<br>Both: $70/week |
| PART TIME | AM only: $22/week<br>PM only: $32/week<br>Both: $45/week |

| SCHOOLS: | NORTH DEARBORN (PM ONLY SITE) |
|---|---|
| FULL TIME | PM only: $50/week |
| PART TIME | PM only: $35/week |

**Full Time: 4 days or more per week**

**Part Time: 3 days or less per week**

# 2018 - 2019 CHILD CARE ENROLLMENT APPLICATION

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

The Enrollment Application consists of a number of forms that must be completed **prior** to your child starting any of our childcare programs.

Today's Date: ___/___/___

Parent Name: _____

| | |
|---|---|
| Name of Child | |
| School Attending (If applicable) | |

*Do you live in the City of Cincinnati limits?* YES NO

*Total number of people in your household:* _____

**Participant's Race:**
☐ White/Caucasian ☐ Black/African-American
☐ Multi-Racial ☐ American Indian
☐ Other ☐ Native Hawaiian/Pacific Islander
☐ Asian ☐ Hispanic

**Household Income:**
☐$0-$20,000 ☐ $20,000-$30,000 ☐
$30,000-$40,000 ☐ $40,000-$50,000
☐$50,000+

## SCHEDULE INFORMATION

My child will be attending the Y's Kids program on these days:

AM: M T W R F AND/OR PM: M T W R F

| CHILD'S INFORMATION | |
|---|---|
| Child's Name: | |
| Birth date & Age: | |
| Grade: | |
| Phone #: | |
| Teacher's Name & Room #: | |
| Parent Birthdate: | |
| Child lives with: | |
| Marital Status of Parents: | |

*** Note: In the case of divorce, adoption, foster parenting, or other court-ordered activity, attach a copy of the court order granting custody

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FOR SOCIAL RESPONSIBILITY

## Parent Acknowledgement & Understanding of YMCA Policies

By signing and dating below, you are acknowledging the knowledge of and the adherence to all of the below policies and procedures associated with these programs. These policies and procedures are outlined in detail in the 2018-2019 Parent Handbook. Your child's safety, security, and health is our number one priority! Our staff goes through extensive training to help ensure the wellbeing of your child. However, through no negligence on anyone's part, accidents may happen. All parents of child care program participants must agree to the following:

- I understand that the YMCA is not responsible for personal property lost or stolen while participating in the program. My child is responsible for all of his/her belongings. I understand that lost and found is reviewed every Friday and that any items left over at the end of each week will be sent to Goodwill®.
- I understand that the YMCA or Greater Cincinnati is not responsible for anything that occurs as a result of false information given by a parent or guardian.
- I understand that any medical expenses resulting from any illness or injury incurred while in the program or attending any YMCA program is my responsibility.
- I understand that the YMCA of Greater Cincinnati assumes no responsibility for injuries or illnesses which may occur as a result of my child's physical condition or resulting from his/her participation in any athletic events, sports programs, the use of any equipment, exercise or other activities.
- I understand that the YMCA is not responsible for my child until the parent/guardian signs them into the program.
- I understand that my child(ren) must be signed in and out of the program they are registered for. This is a state law and must be done every day. If someone else picks my child up they will need to complete the sign in/out sheet.
- I acknowledge the receipt of the Parent Handbook. I understand that I am responsible for reading the handbook and understanding all of its content. I agree to follow all of the terms that are covered in the manual.
- I understand that payment is due by 6:00 pm Friday, for the following week. If my payment is not received by then, I understand that it is my responsibility to add a **$10.00 late fee** to my payment. If my payment is more than one week late, I understand that it will result in the removal of my child from the program, and I will be charged an additional registration fee upon return. I understand that a credit/debit card **must** be on file and **no cash payments will be accepted at the center.** The only time the weekly fee will be prorated is if the program is closed more than three days a week.
- I understand that there is a late fee of $1.00 per minute/per child for any child left after the time they are registered for. This payment will be made upon my arrival, in cash and given to the staff person who remains after scheduled work hours to be with my child.
- I understand that if I withdraw from the program I must provide the Program Director with notice in writing at least 2 weeks prior. Also, changes to my child's program attendance schedule must be made in writing no less than two weeks prior to the date of the scheduled change using a *Change of Program* form.
- I understand that the Director or acting Director will take whatever steps necessary to obtain emergency medical care if warranted.
- I understand that the YMCA Child Care programs will follow the public-school schedule of my county/district. If the children are scheduled to be off from school for the day and I still need childcare, I must register my child/children for the Schools Day Out program for an additional charge. I am aware that this information is outlined in the Parent Handbook.
- I understand that under no circumstances will my child bring their own toys or other personal items, which include but are not limited to: personal electronic devices, cell phones, card games, etc. If my child does so, the staff will confiscate the item and return it to the parent at the end of the day.
- I understand that I MUST turn in all requested paperwork completed in full, **prior** to the start of the program.

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FOR SOCIAL RESPONSIBILITY

# 2018 - 2019 CHILD CARE

## Permission to Participate

Please indicate by checking yes or no to what activities that you will provide permission for your child during child care programming.

☐ Yes ☐ No I give my permission for my child to use all of the equipment and participate in all activities involved in the program.

☐ Yes ☐ No I give my permission for my child's image, voice, or written comments to be included in evaluations, pictures, newsletters, and marketing pieces associated with the program. The YMCA of Greater Cincinnati may use these indefinitely, without limitation or obligation for the purpose of promoting or interpreting YMCA programs.

Must Complete!

**ADULTS AUTHORIZED TO PICK UP MY CHILD (must be at least 18 years of age)**
**PLEASE INCLUDE YOURSELF AND SPOUSE (should spouse apply).**

| NAME | RELATIONSHIP TO CHILD | PHONE NUMBER |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Parent Handbook:

I have read and understand the contents of the **2018-2019 Parent Handbook** and agree to all the terms that are covered in the manual.

I understand that my signature indicates that I have been previously made aware of all policies, procedures, and guidelines referenced in the handbook concerning this program.

## Agreement to Terms and Conditions:

I have read and fully understand these policies and authorization statements. I do hereby give such authorization as indicated or document understanding of specified policies.

_____
Name of Child (Please Print)

_____
Parent/Guardian Name (Please Print)

_____
Parent/Guardian Signature

_____ /_____ /_____
Date

School-Age

Ohio Department of Job and Family Services

# FAMILY INFORMATION
# FOR STEP UP TO QUALITY PROGRAMS (SUTQ)

| Child's Name *(Last)* | *(First)* | Nickname *(If any)* |
|---|---|---|
| | | |

***By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child.***

Who is in the child's immediate family?

Who lives at home with your child?

What is the primary language spoken in your child's home?

Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.? Additional Details?

Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new home, death of family member, friend or pet) Additional Details?

Are there any cultural or religious practices of your family we should be aware of? (Dietary restrictions, clothing, head coverings, etc.)

Do you have any pets at home? If so, what are they and what are their names?

Has your child had a previous care arrangement? ☐ Yes or ☐ No Additional Details? (Center based, in home, with family, with parents, etc.)

My child drinks ☐ milk, ☐ formula, ☐ juice or ☐ water. *(Check all that apply)*
How much and how often?

Does your child have any favorite foods?

Does your child dislike any foods?

Are there any foods your child should not be fed? (Licensing requires documentation be completed for children with food allergies and/or dietary restrictions)

Please check all of the words that best describe your child's personality and behavior

☐ active ☐ adventurous ☐ affectionate ☐ anxious ☐ bossy ☐ bright ☐ busy ☐ calm ☐ cautious ☐ cheerful
☐ content ☐ creative ☐ curious ☐ easily-angered ☐ emotional ☐ energetic ☐ excitable ☐ friendly ☐ gives-in-easily
☐ happy ☐ hesitant ☐ insecure ☐ jealous ☐ likes structure/routines ☐ loud ☐ loving ☐ mellow ☐ outgoing
☐ prefers adult attention ☐ quiet ☐ sensitive ☐ serious ☐ shares-well ☐ social ☐ spontaneous ☐ stubborn ☐ tentative
☐ other:

Are there additional personality and behavior characteristics that would be useful to know about your child?

Are there things that frighten your child? If so, how does he/she react and what do you do to comfort him/her?

What routines/actions or items do you use to comfort your child?

What causes your child to feel angry or frustrated?

What methods do you use to respond to your child's negative behavior?

Does your child use any special comfort or support items that help him/her go to sleep? If so, what?

What is your child's mood upon waking? (happy, grouchy, clingy, slow to awaken)?

What time does your child normally go to bed at night and wake up in the morning?

| Does your child have trouble sleeping (Night terrors, trouble going to sleep, etc.)? Please explain. |
|---|
| |
| What might you and/or your child be anxious about as he/she starts in this program? |
| |
| What are you and/or your child excited about as he/she starts in this program? |
| |
| What are your expectations of this program? |
| |
| What other information would be helpful for the staff caring for your child to know? |
| |

| Parent/Guardian's Signature | Date |
|---|---|
| | |

Must Complete!

Ohio Department of Job and Family Services

# CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE

**This form shall be completed prior to the child's first day of attendance and updated annually and as needed.**

| | | |
|---|---|---|
| Child's Name | Date of Birth | First Day at Program/Home |
| Home Address | | City |
| State | Zip Code | Home Telephone Number |
| Parent/Guardian Name | | Relationship to Child |
| Home Address | | Home Telephone Number |
| City | | State / Zip |
| Email Address *(if applicable)* | Cell Phone | |
| Parent's Work/School Telephone Number | Parent's Work/School Name | |
| Parent's Work/School Address | | City |

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

| | | |
|---|---|---|
| Parent/Guardian Name | | Relationship to Child |
| Home Address | | Home Telephone Number |
| City | | State / Zip |
| Email Address *(if applicable)* | Cell Phone | |
| Parent's Work/School Telephone Number | Parent's Work/School Name | |
| Parent's Work/School Address | | City |

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

**Emergency Contacts:** Parents **cannot be listed** as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness if you cannot be reached. Any person listed should be able to assist in contacting you. At least one person listed must be within one hour of the center/home, able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

| | |
|---|---|
| Name | Name |
| City / State | City / State |
| Telephone Number / Relationship to Child | Telephone Number / Relationship to Child |
| Other numbers where emergency contact can be reached *(if applicable)* | Other numbers where emergency contact can be reached *(if applicable)* |

Must fill out all information

| | | |
|---|---|---|
| Name of Physician or Clinic/Hospital | | |
| Street Address | | |
| City | State | Telephone Number |

Must Complete!

Child's Name

**Allergies, Special Health or Medical Conditions, and Food Supplements**

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or family child care home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

☐ No

☐ Yes - check all that apply ☐ Food ☐ Medication ☐ Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms, take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Does your child have a special health or medical condition? (*check one*)

☐ No

☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication, food supplement, or medical food need to be administered at the child care center/type A home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.

☐ N/A - program does not administer any medications.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

☐ No

☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

☐ No

☐ Yes - written instructions from the child's health care provider must be on the JFS 01217 "Request for Administration of Medication."

☐ N/A - child does not attend a full time program.

Must Complete!

| Child's Name |
|---|
| List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff or medical personnel in an emergency situation. |
| List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page. |

**Diapering Statement**

Is your child toilet trained? ☐ Yes (If yes, skip to Emergency Transportation Authorization section) ☐ No (If no, fill out the following)

The program's policy is to check diapers every _____ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every _____ hours.

**Emergency Transportation Authorization**

| Give ***Permission*** to Transport | | | ***Do Not Give Permission*** to Transport | |
|---|---|---|---|---|
| Program or Home Name | | | Program or Home Name | |
| **has permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported. | | **OR** Do not sign both | **does not have permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken: | |
| Parent's Signature | Date | | Parent's Signature | Date |

**Acknowledgement of Policies and Procedures**

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. ☐ Yes ☐ No *(check one)*

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

| Parent/Guardian Signature(s) | Date |
|---|---|
| Administrator/Designee Signature | Date |

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

| Parent/Guardian Initials | Date of Review | Administrator/Designee Initials | Date of Review |
|---|---|---|---|
| Parent/Guardian Initials | Date of Review | Administrator/Designee Initials | Date of Review |
| Parent/Guardian Initials | Date of Review | Administrator/Designee Initials | Date of Review |

Note: This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15 and 5101:2-13-15. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

If your child has a special health condition, ie. asthma, allergy, skin condition, this form must be filled out & signed by the ★'s

Ohio Department of Job and Family Services

# CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE

| Child's Name | Date of Birth |
|---|---|
| Special Health Conditions | |
| Symptoms to watch for and emergency action to be taken if the following symptoms occur | |
| Activities/foods/environmental conditions to avoid, if applicable | |
| Medical procedures to be followed and expected benefit of treatment, if applicable | |
| Are any medications required? ☐ Yes ☐ No *(If yes, complete JFS 01217 "Request for Administration of Medication")*<br>If yes, what medications? | |
| In an emergency does this child require additional assistance (more than other children of the same age or in the same group) to evacuate?<br>☐ Yes ☐ No | |
| In the event that the child care program must be evacuated, are there medications or supplies that must be taken with this child?<br>☐ Yes ☐ No | |
| Training Instructions *(Trainer must be a parent or certified professional)* | |
| ★ Signature of Trainer | Date |

Signature of trained providers, substitutes or child care staff members who have been made aware of the condition.
*(There must always be a trained caregiver present when the child is present)*

| Signature | Date | I have been ☐ Informed | I have been ☐ Trained |
|---|---|---|---|
| Signature | Date | I have been ☐ Informed | I have been ☐ Trained |
| Signature | Date | I have been ☐ Informed | I have been ☐ Trained |
| Signature | Date | I have been ☐ Informed | I have been ☐ Trained |

*(Only trained providers, substitutes or child care staff members shall be permitted to perform medical procedures listed above.)*

| Additional services (educational/therapeutic) child is receiving | | |
|---|---|---|
| Who provides the above services? | | |
| Name | Phone Number | May we contact? ☐ Yes ☐ No |
| Name | Phone Number | May we contact? ☐ Yes ☐ No |

I give my permission for the staff listed above to perform the procedures in my child's Medical/Physical Care Plan.

| ★ Parent Signature | Date |
|---|---|
| Administrator/Provider Signature | Date |

*Note: A separate plan must be written for each condition that requires different actions to be taken*

Ohio Department of Job and Family Services

# REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

| Box 1 | The following section must always be completed by the parent/guardian. |
|---|---|

Check all that apply and complete all of the information.

☐ Prescription Medication ☐ Nonprescription Medication ☐ Food Supplement

☐ Topical Product or Lotion ☐ Refrigeration Required ☐ Modified Diet

| Name of Child | Date of Birth | Weight |
|---|---|---|
| | | |

| Name of Medication | Exact Dosage |
|---|---|
| | |

| To be administered at the following times | For the following period of time |
|---|---|
| | |

☐ I understand that my child must receive one dose of medication before arriving at the program (unless the medication is used for emergencies).

| Signature of Parent/Guardian | Date |
|---|---|
| | |

| Box 2 | The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant. |
|---|---|

1. The medication contains codeine or aspirin.
2. A physician's instruction is needed for a nonprescription medication (e.g. child does not meet minimum age or weight requirements as listed on the label instructions).
3. It is a sample medication without a prescription label.
4. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period.
5. The topical product or lotion and the physician's instructions exceed the manufacturer's instructions or use.

| Name of child | Name of medication, vitamin, diet, supplement |
|---|---|
| | |

| Dosage | Possible side effects to watch for are |
|---|---|
| | |

Expiration date

(May not exceed twelve months from the date of this request for medications of food supplements).

Instructions

This child is under my care and should receive the above medication as written.

Signature of physician, dentist, advanced practice registered nurse or certified physician's assistant

| Date of signature | Phone number |
|---|---|
| | |

| Name of child | Name of medication, vitamin, diet, supplement |
|---|---|
| | |

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

| Box 3 | The following section must be completed by the center, family child care provider or in-home aide for the child listed on page one of this form. All medication must be documented when administered. | | |
|---|---|---|---|
| Date | Time | Dosage | Signature of Designated Person Administering Medication |
| | | | |
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This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

FOR YOUTH DEVELOPMENT®
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# NWLSD Emergency Closing

In the event of an emergency closing for Northwest School District, the YMCA will run a program at the Clippard branch. To take advantage of this program you must fill out the bottom half of this sheet and return the whole sheet to your Site Administrator, you must have a completed enrollment packet for our before and after school program as well. Your registration fee is due at that time. **We will not provide a meal for this program so you must pack your child a lunch,** please dress them weather appropriate and please pack your child a swimsuit. The program will run from 6:30 AM to 6:00 PM with a $1 per minute charge for students picked up after 6:00 PM.

**Vouchers will not be accepted for this program**

Registration Fee: $10 per child,
$5 per child for families receiving assistance

Program Fee: $30 per child,
$15 per child for families receiving assistance
The Program Fee is due upon arrival to the program.

We will be accepting registration for this program until November 1st and space is limited.

Name of Child(ren): _____

Parent Signature: _____
Date: _____

the YMCA
FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

# 2018 - 2019 CHILD CARE

If you will be using Hamilton County Vouchers for Y's Kid's before and/or after school program, please fill out the information below to ensure that your child is authorized before the first day of care. If we do not receive the information we need, you will be responsible for full payment until the information is provided.

☐ If you plan to make the child care connection on your own, prior to your child beginning Y's Kid's, please check this box. Note, when making a connection it takes 5-7 business days to complete.

| | |
|---|---|
| Case Number ** | |
| Parent SSN | |
| Parent Name (First and Last) | |
| Child Name (First and Last) | |
| First day attending | |

** Case number begins with 600

If you have any questions or concerns regarding your voucher or swipes, you can contact our registrar, Rebecca Vonallmen, via email at rvonallmen@myy.org

the YMCA
FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

# YMCA of Greater Cincinnati Voucher Agreement

Please read the following policies for families using vouchers and the Ohio ECC swipe card system for child care.

Your responsibilities in this process are as follows:

- You are responsible for paying your parent fee as designated by Hamilton County Department of Job and Family Services. The fee must be paid no later than **6 pm on Friday** prior to the week of service.
- You are responsible for swiping your child in and out **EVERY day**. **Do not wait to swipe your child in and out on Friday, this causes a long wait at the voucher machine and is unfair to other parents.**
- If you miss a swipe, you are responsible for doing a previous swipe and correctly recording the time your child arrived/departed. Back swipes can be made up to 2 weeks after the attended week, manual claims will not be given out because of forgotten back swipes, and you are responsible for making sure they are made.
- Each child has a total of 10 absences to use within a 6 month period. Each absence is worth 5 hours, it is up to our registrar to decide when it is appropriate to use 1 or possibly 2 to ensure payment for that week.
- You are responsible for telling your child care caseworker if you change your address or phone number.
- It is your responsibility to call your caseworker and adding the school site as an authorized provider before your child attends the program. For School's Day Out, add the YMCA as the authorized provider.
- If you receive an error or denied message when swiping your card, it is your responsibility to notify the registrar immediately.
- **For part time programs such as before and after school, if the child does not attend at least 7 hours and does not have any absences left to reach the 7 hour minimum, the parent is then held responsible for the full program price. For full time programs you must reach 25 hours for payment to be received.**

I, _____, have read and understand my responsibilities in regards to the Ohio ECC Swipe Card System.

Signature:_____ Date: _____

the YMCA FOR YOUTH DEVELOPMENT FOR HEALTHY LIVING FOR SOCIAL RESPONSIBILITY

**2018 - 2019 CHILD CARE**

# Clippard Family YMCA SACC Program

## Mandatory Automatic Payment Enrollment

* Automatic payment enrollment is now required for all Clippard YMCA childcare participants.

Payment Policies:

- ✓ **A valid credit/debit card must be on file for all weekly payments.** Only the registration fee and deposits may be paid by other means.
- ✓ **My credit/debit card will be charged in full for any programs I have selected, on the Friday *before* the selected week.**
- ✓ I will be charged in full **(whether or not my child attends)** unless I withdraw my child from the selected program using the Status Change Form and return it no later than 2 weeks before the start of the selected week.
- ✓ If my card is rejected, I will be notified no later than the Monday of the week of service. **My child will not be able to return to the selected program until the fee is paid and a valid card is on file.**

*The information on this form will be kept in a locked safe in a secure location and shredded after each school year

Parent Name: _____

Phone #: _____ Membership #: _____

Child(ren)'s Name(s): 1. _____ 2. _____

3. _____ 4. _____

☐ I understand that my card will be charged on the Friday before each week of the program.

Select Card Type: ☐ Visa ☐ MasterCard ☐ American Express

Card Holder Name: _____ Card # _____ Exp. _____

Billing Address: _____ City: _____ Zip: _____

I understand and agree to the above payment policies. I authorize Clippard Family YMCA to charge the full fee for all programs selected on the registration form to the credit/debit card listed above.

Signature: _____ Date: _____