# Ashland Child Development

1538 Central Avenue, Post Office Box 2246, Ashland, Kentucky 41105-2246
606-329-1744 or 606-329-1550

A Public, Non-profit, Educational Agency

# FINANCIAL CONTRACT

1. It is my desire to enroll _____.

2. I hereby agree to pay on Monday of each week the sum of $_____ per week for the following services. ☐ FULL DAYS (9 HOURS) ☐ HALF DAYS (5 HOURS) ☐ SUBSIDISED

I understand any additional services requested will adjust the above rate and all rates are subject to change as conditions may require.

3. **FAMILY REGISTRATION FEE:**
I understand that a registration fee of $20.00 is to be paid at the time of enrollment. The fee is nonrefundable. A new registration fee is required each September 1st. If child's first month is July or August another fee of $20.00 will not be billed to you.

4. **BILLING:**
**Self Paid**: Payment expected before services rendered. You will be expected to pay your contract for up coming week. If you go over your contract, payment will be collected the following Monday. **Subsidized**: Co-pay must be paid before services rendered. This will be collected every Monday.
   - **A. Contract will be charged whether child/children attend or not.**
   - **B. NO CHARGE for 2 weeks vacation per year. Must be 5 days in a row. (Prior notice) This excludes families with child care assistance because we can bill 5 absences per month.**
   - **C. Child/children can not be in attendance unless bill is paid. NO EXCEPTIONS**
   - **D. You will be billed for 6 Holidays throughout the year.**
   - **E. ACDC's week runs from Monday – Friday.**

5. **LATE FEES:**
I understand that if my child remains at Ashland Child Development past closing time, I will be charged (and agree to pay) $5.00 per minute past closing time. (5:30).

6. **WITHDRAWAL:**
I understand that if my child is absent for two weeks without explanation, my child will automatically be discharged from Ashland Child Development Center. After payment is made in full, we will be glad to reinstate your child if a spot is available.

7. **RETURNED CHECK POLICY:**
I understand and agree that for any returned check, $50.00 will automatically be charged to my account as a processing fee and must be paid before child can return to center.

I have read the above and thoroughly understand all terms.

_____ Date: _____
Parent or Guardian Signature:

_____ Date:_____
Administrator