Ashland Child Development Center

A Public, Non-Profit, Educational Agency

Toddler, and Preschool Programs

OFFICE USE ONLY
Enrollment Date_____
Class or Group _____
Fin Agree on File_____
Food Form _____
Orig. Reg. Fee Paid _____
Medical Complete_____
Weekly or Bi-Weekly _____

GENERAL INFORMATION

Name of Student: _____ Social Security Number: _____

Address:_____ Phone: _____

Date of Birth: _____ Age as of October 1:_____

Parents: ☐ Married ☐ Divorced ☐ Separated

Father's Name _____ Place of Employment_____

Work Phone: _____ Work Address: _____

Social Security Number: _____

Mother's Name _____ Place of Employment_____

Work Phone: _____ Work Address: _____

Social Security Number: _____

If neither mother or father can be reached in case of emergency, please list who may be called or may pick up:

Name Address Relationship Phone No.

_____

I found out about ACDC from: ☐ a friend ☐ newspaper ☐ mail ☐ T.V. ☐ other _____

Name of child's doctor: _____ Phone _____

Name of child's dentist: _____ Phone _____

If emergency medical care is necessary, I give you permission for any treatment deemed necessary by a physician and/or hospital of your choice.

Who is authorized to pick up your child other than the enrolling parent?

Name Address Relationship Phone No.

_____

_____

☐ I hereby grant permission for my child to participate in all center activities, including transportation to and from school. I also grant permission to use photographs of my child.

☐ I hereby release, indemnify and hold harmless Ashland Child Development and its staff from any loss or damage to toys, clothes or other personal articles.

☐ I hereby release, indemnify and hold you, your agents and employees harmless from any and all claims, damages or other liabilities for injuries to or damage by my child which are not a result of gross negligence by Ashland Child Development, its agents or employees.

☐ I hereby warrant to Ashland Child Development that I am entitled to legal custody and possession of my child, and accordingly am authorized to place my child in your care and custody, and am further authorized to sign this enrollment form.

_____ _____

Date Parent or Guardian's Signature

Ashland Child Development Center

A Public, Non-Profit, Educational Agency

OFFICE USE ONLY

Enrollment Date_____

Class or Group _____

Fin Agree on File_____

Food Form _____

Orig. Reg. Fee Paid _____

Medical Complete_____

Weekly or Bi-Weekly _____

School Age Program

GENERAL INFORMATION

Name of Student: _____ Social Security Number: _____

Address:_____ Phone: _____

Date of Birth: _____ Age as of October 1:_____

Parents: ☐ Married ☐ Divorced ☐ Separated

Father's Name _____ Place of Employment_____

Work Phone: _____ Work Address: _____

Social Security Number: _____

Mother's Name _____ Place of Employment_____

Work Phone: _____ Work Address: _____

Social Security Number: _____

If neither mother or father can be reached in case of emergency, please list who may be called or may pick up:

Name Address Relationship Phone No.

_____

I found out about ACDC from: ☐ a friend ☐ newspaper ☐ mail ☐ T.V. ☐ other _____

Name of child's doctor: _____ Phone _____

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If emergency medical care is necessary, I give you permission for any treatment deemed necessary by a physician and/or hospital of your choice.

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☐ I hereby warrant to Ashland Child Development that I am entitled to legal custody and possession of my child, and accordingly am authorized to place my child in your care and custody, and am further authorized to sign this enrollment form.

_____ _____

Date Parent or Guardian's Signature

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

Revised FY2015-2016

CHILD ENROLLMENT FORM/INCOME APPLICATION

1. Participant Information: (To be completed by Parent/Guardian)

If a child is a SNAP/K-TAP recipient or a Kinship/Foster/Head Start participant, the child is automatically eligible to receive free Program meal benefits, subject to the requirements of 7 CFR 226.23.

If your participant receives assistance from the items below, they are automatically eligible for free meals. (Please complete and skip to section 3.)

Participant's Last Name	Participant's First Name	Date of Birth	Normal Typical Hours of Care	Normal/Typical Days of Care (Circle all that apply)	Meals Normally Eaten (Circle all that apply)	Snap or K-TAP #	Kinship	Foster
			-	M T W Th F Sa Su	B AM L PM S LN		☐	☐
			-	M T W Th F Sa Su	B AM L PM S LN		☐	☐
			-	M T W Th F Sa Su	B AM L PM S LN		☐	☐
			-	M T W Th F Sa Su	B AM L PM S LN		☐	☐
			-	M T W Th F Sa Su	B AM L PM S LN		☐	☐

***Parent/Guardian works multiple shifts and participants may be in care different days/hours ____yes ____no**

2. Income Application Household Members and Monthly Income:

NAMES OF HOUSEHOLD MEMBERS Including Children Not Listed Above **Last, First**	**GROSS MONTHLY** Income From Work (Before Deductions)	**MONTHLY** Income From Welfare Payments, Child Support, Alimony	**MONTHLY** Income From Pensions, Retirement, Social Security, Unemployment Compensation	Any Other **MONTHLY** Income Including Money Received from Kinship/Foster Child
1.	**$**	**$**	**$**	**$**
2.	**$**	**$**	**$**	**$**
3.	**$**	**$**	**$**	**$**
4.	**$**	**$**	**$**	**$**
5.	**$**	**$**	**$**	**$**

3. Signature and Social Security Number:

I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.

X_____

Signature of Adult Household Member

X_____ ☐ No Social Security Number X_____

Last four digits Social Security Number* **Date**

FOR SPONSOR USE ONLY. DO NOT WRITE BELOW THIS LINE.

Application approved for:

☐ Free Meals
☐ Reduced Price Meals
☐ Paid

☐ SNAP/KTAP
☐ Foster/Kinship
☐ Income Household

Total Household Monthly Income_____

Household Size_____

_____
Signature of Determining Official

_____
Date

**7 CFR 226.15 (e)(2)*

"USDA is an equal opportunity provider and employer."

"The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The last four digits of the Social Security Number are not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program."

INCOME ELIGIBILITY GUIDELINES
For Child Care Centers
(FOR INTERNAL/OFFICE USE ONLY)

INCOME ELIGIBILITY SCALE

The eligibility scale is for determining participating children's eligibility category for federal meal reimbursement if they are not recipients of SNAP (Formerly food stamps) or K-TAP. Participants from households with total gross incomes at or below the following levels may be eligible for free or reduced-price reimbursement rates.

Income Guidelines for Free/Reduced Price Meals Effective July 1, 2016-June 30, 2017				
Household Size	**Free Meals**		**Reduced Price Meals**	
	Monthly	***Yearly***	***Monthly***	***Yearly***
1	**$1,287**	$15,444	**$1,832**	$21,978
2	**$1,736**	$20,826	**$2,470**	$29,637
3	**$2,184**	$26,208	**$3,108**	$37,296
4	**$2,633**	$31,590	**$3,747**	$44,955
5	**$3,081**	$36,972	**$4,385**	$52,614
6	**$3,530**	$42,354	**$5,023**	$60,273
7	**$3,980**	$47,749	**$5,663**	$67,951
8	**$4,430**	$53,157	**$6,304**	$75,647
For each additional family member add:	**+$451**	+$5,408	**+$642**	+$7,696

* The term “household” means a group of related or unrelated individuals who are not residents of an institution or boarding house but who are living as one economic unit, sharing housing and all significant income and expenses.

Note: Children that are recipients of the following programs are automatically eligible for the free reimbursement rate:

- SNAP (formerly known as Food Stamps)
- Kentucky Transitional Assistance Program (K-TAP)
- Foster Care Program
- Head Start or Even Start
- Kinship

We Need An Update from You!

Ashland Child Development Center wants to keep in touch! Please update the email address that we can send information to regarding:

- Emergency Closings
- Program Happenings
- Newsletters

Parent Name _____

Email Address _____

Child's Name _____

Like us on Facebook to see pictures and updates of the happenings at the Center!

Ashland Child Development CHILD'S HEALTH AND EMERGENCY INFORMATION

Child's Name: _____ Birth Date: _____

Parent or Guardian Name (s): _____ Home Telephone: _____

Home Address: _____ Cell Phone: _____

Mother's/Guardian's Place of Work: _____ Telephone #: _____

Father's/Guardian's Place of Work: _____ Telephone #: _____

Only the following people can pick up my child:

Name	Telephone #	Relationship to child
Name	Telephone #	Relationship to child

GENERAL STATUS OF CHILD'S HEALTH: _____

Allergies or restrictions on child's participation in activities: _____

Specific instructions from parent or physician: _____

IN EMERGENCY, when parent cannot be reached, notify:

Name: _____ Relationship to child: _____
Address: _____ Phone #: _____ Cell #: _____
Name of Physician: _____ Phone #: _____
Name of Hospital: _____ Phone #: _____

PERMISSIONS: In case of accident or illness requiring medical attention in the parent/guardian's absence, I authorize:

Ashland Child Development Center to seek emergency medical care for _____
Child's Name

I give permission for **Ashland Child Development Center** to transport _____
Child's Name

I have received a copy of the child and parent rights as required by KRS 199.898. (Section 14 (4) and have received the name, address, and telephone number of the Cabinet for registering a complaint if I believe the family child care home provider is not meeting family child care standards. (Section 14 (3).

_____ _____
Signature of Parent or Guardian Date

CITY OF ASHLAND PLANNING & COMMUNITY DEVELOPMENT DEPARTMENT
Community Development Block Grant
1700 Greenup Avenue, PO Box 1839, ASHALND, KY 41105 ·(606) 327-2030 · FAX (606) 325-8412

RACE AND ETHNIC DATA REPORTING FORM

Program Name: ASHLAND CHILD DEVELOPMENT (Utility Grant).
Head of Household Name: _____
Household Member Name: _____
Property Address: 1538 Central Avenue, Ashland, KY .

PLEASE COMPLETE THIS FORM FOR EACH PERSON IN YOUR HOUSEHOLD. Parents and guardians are to complete the form for children under the age of 18.

Ethnic Categories	Select One
Hispanic or Latino	
Not Hispanic or Latino	

Racial Categories	Select All That Apply
American Indian or Alaska Native	
Asian	
Black or African American	
Native Hawaiian or Other Pacific Islander	
White	
Other	

There is no penalty for persons who do not complete the form.

Household Signature: _____ **Date:** _____

Agency Signature: _____ **Date**: _____

Public reporting burden for this collection is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. This information is required to obtain benefits and voluntary. HUD may not collect this information, and you are not required to complete this form, unless it displays a currently valid OMB control number. This information is authorized by the U.S. Housing Act of 1937 as amended, the Housing and Urban Rural Recovery Act of 1983 and Housing and Community Development Technical Amendments of 1984. This information is needed to be in compliance with OMB-mandated changes in Ethnicity and Race categories for recording the 50059 Data requirements to HUD. Owners/agents must offer the opportunity to the head and co-head of each household to “self-certify” during the application interview or lease signing. This process will allow the owner/agent to collect the needed information on all members of the household. Completed documents should be stapled together for each household and placed in the household’s file. Parents or guardians are to complete the self-certification of children under the age of 18. The information is considered non-sensitive and does not require any special protection.

***Definitions of these categories may be found on the reverse side.**

Ashland Child Development
A Public, Non-Profit, Educational Agency
1538 Central Avenue · Post Office Box 2246
Ashland, Kentucky 41105-2246
606 329-1744 · 606 329-1550 · Fax: 606 324-6465
ashchilddevel@yahoo.com · ACDChildcare.org

Waiver and Release

I agree to allow my child/children to be included in photos and any other advertisements or promotions that Ashland Child Development Center, Inc. may decide to develop now or in the future. I also hereby agree to waive any right of claim to any compensation, fees or other benefits.

Name of child/children: _____

_____

I certify that I am the legal parent or guardian of the child/children identified above.

Parent/Guardian Signature: _____

Date: _____