



**MUST HAVE TO REGISTER FOR 2026-2027 ELC:**

- Child Care Enrollment Form**
- Income Eligibility Form**
- Medication Authorization**
- Child Medical Examination Report**
- ELC Program Fee**
- Account Access Authorization**
- Extra Curricular Activities**
- Bank Draft Form**
- DCN Number & Proof of approval letter  
(must have if applicable)**



MISSOURI DEPARTMENT OF ELEMENTARY MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
AND SECONDARY EDUCATION BUREAU OF COMMUNITY FOOD & NUTRITION ASSISTANCE  
OFFICE OF CHILDHOOD – CHILD CARE COMPLIANCE

**CHILD CARE ENROLLMENT FORM**

FACILITY/PROVIDER NAME	ADMISSION DATE	DISCHARGE DATE
CHILD'S NAME	GENDER	BIRTHDATE

CHILD'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

**IDENTIFYING INFORMATION**

PARENT/GUARDIAN NAME	TELEPHONE NUMBER
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ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS CHILD'S ADDRESS

EMAIL ADDRESS

EMPLOYER OR SCHOOL	WORK/SCHOOL SCHEDULE
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EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER
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PARENT/GUARDIAN NAME	TELEPHONE NUMBER
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ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS CHILD'S ADDRESS

EMAIL ADDRESS

EMPLOYER OR SCHOOL	WORK/SCHOOL SCHEDULE
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EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER
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If you or a member of your immediate family ever served in the U.S. Armed Forces, [click here for more information about military-related services in Missouri](#) or visit [www.dese.mo.gov/veterans-services](http://www.dese.mo.gov/veterans-services).

**EMERGENCY CONTACT AND PERSONS AUTHORIZED TO TAKE CHILD FROM FACILITY OTHER THAN PARENT (AT LEAST ONE EMERGENCY CONTACT IS REQUIRED)**

NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBER(S)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBER(S)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

The Department of Elementary and Secondary Education does not discriminate on the basis of race, color, religion, gender, gender identity, sexual orientation, national origin, age, veteran status, mental or physical disability, or any other basis prohibited by statute in its programs and activities. Inquiries related to department programs and to the location of services, activities, and facilities that are accessible by persons with disabilities may be directed to the Jefferson State Office Building, Director of Civil Rights Compliance and MOA Coordinator (Title VI/Title VII/Title IX/504/ADA/ADAAA/Age Act/GINA/USDA Title VI), 5th Floor, 205 Jefferson Street, P.O. Box 480, Jefferson City, MO 65102-0480; telephone number 573-526-4757 or TTY 800-735-2966; email [civilrights@dese.mo.gov](mailto:civilrights@dese.mo.gov).

**COMMENTS ON CHILD'S DEVELOPMENT  
(PERSONAL DEVELOPMENT, BEHAVIOR, PATTERNS, HABITS, & INDIVIDUAL NEEDS)**

**RELATED CHILD**

<input type="checkbox"/> Yes <input type="checkbox"/> No	CHILD'S RELATION TO CHILD CARE PROVIDER
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**ETHNIC AND RACE INFORMATION (YOU ARE NOT REQUIRED TO ANSWER THIS SECTION)**

Are you of Hispanic or Latino origin?  Yes  No

What is your race? (Select one or more.)	<input type="checkbox"/> American Indian or Alaskan native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Native Hawaiian or other Pacific Islander	<input type="checkbox"/> White
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**CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED**

**CACFP REQUIREMENT**

Will child attend: <input type="checkbox"/> Full time <input type="checkbox"/> Part time		When does your child usually arrive each day?	When does your child usually leave each day?	Describe any changes or variations in usual attendance, including shift changes.
Check what days your child will attend.				
Monday	<input type="checkbox"/>	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
Tuesday	<input type="checkbox"/>	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
Wednesday	<input type="checkbox"/>	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
Thursday	<input type="checkbox"/>	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
Friday	<input type="checkbox"/>	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
Saturday	<input type="checkbox"/>	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
Sunday	<input type="checkbox"/>	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	

**MEALS YOUR CHILD IS USUALLY GIVEN AT THIS FACILITY**

Breakfast     Morning snack     Lunch     Afternoon snack     Supper     Evening snack     None

**HOLIDAYS YOUR CHILD IS IN CARE AT THIS FACILITY**

<input type="checkbox"/> New Year's Day Martin Luther King, Jr.'s Birthday Lincoln's Birthday Washington's Birthday	<input type="checkbox"/> Easter <input type="checkbox"/> Truman Day <input type="checkbox"/> Memorial Day <input type="checkbox"/> Juneteenth <input type="checkbox"/> Independence Day	<input type="checkbox"/> Labor Day <input type="checkbox"/> Columbus Day <input type="checkbox"/> Veterans Day <input type="checkbox"/> Thanksgiving Day <input type="checkbox"/> Christmas Day
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## AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I understand that I will be notified at once in the event of an emergency with my child, and I will make arrangements for medical care of my child with the physician or hospital of my choice. If I cannot be reached to make the necessary arrangements, or in a critical emergency requiring medical care, I authorize

\_\_\_\_\_ (CHILDCARE FACILITY NAME)

to contact the following:

### PHYSICIAN OR CLINIC

NAME	TELEPHONE NUMBER
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### PREFERRED HOSPITAL

NAME	TELEPHONE NUMBER
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### ACKNOWLEDGMENTS

<b>A</b>	I have received a copy of this facility's policies pertaining to the admission, care, and discharge of children.	PARENT/GUARDIAN INITIALS
<b>B</b>	I have been informed that a copy of the licensing rules for child care home or the licensing rules for group child care homes and centers is available at this facility for review.	PARENT/GUARDIAN INITIALS
<b>C</b>	The provider and I have agreed on a plan for continuing communication regarding my child's development, behavior, and individual needs.	PARENT/GUARDIAN INITIALS
<b>D</b>	When my child is ill, I understand and agree that s/he may not be accepted for care or remain in care.	PARENT/GUARDIAN INITIALS
<b>E</b>	I understand that, before the first day of attendance by my child, I will provide proof of completed age-appropriate immunizations or exemption from immunizations.	PARENT/GUARDIAN INITIALS
<b>F</b>	I <input type="checkbox"/> do <input type="checkbox"/> do not give permission for field trips/excursions. I understand that I will be notified in advance when they are planned.	PARENT/GUARDIAN INITIALS
<b>G</b>	I <input type="checkbox"/> do <input type="checkbox"/> do not give permission for the facility to transport my child.	PARENT/GUARDIAN INITIALS
<b>H</b>	I have been informed and have received a copy of the facility's safe sleep policy when enrolling a child less than one (1) year of age.	PARENT/GUARDIAN INITIALS
<b>I</b>	I have been notified that I may request notice at initial enrollment or at any time thereafter whether there are children currently enrolled in or attending the facility for whom an immunization exemption has been filed.	PARENT/GUARDIAN INITIALS

PARENT/GUARDIAN SIGNATURE	DATE
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<b>REQUIREMENT</b>	FIRST ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
	SECOND ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
	THIRD ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE

### **USDA Nondiscrimination Statement**

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**  
U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW Washington,  
D.C. 20250-9410; or
2. **fax:**  
(833)256-1665 or (202) 690-7442; or
3. **email:**  
[program.intake@usda.gov](mailto:program.intake@usda.gov)

This institution is an equal opportunity provider.

**Child and Adult Care Food Program  
Parent Letter – Non-Pricing Child Care Centers  
July 1, 2025 through June 30, 2026**

Dear Parent or Legal Guardian:

Our center is currently participating in the Child and Adult Care Food Program. This program reimburses the center for the partial cost of meals provided to children and allows the center to provide nutritious meals without increasing the center's fees to you. If your yearly income is equal to or below the amount listed for your family size on the chart below, your child is eligible for free or reduced-price meals. If the income is higher than the amount listed for your family size, you do not need to complete the income application.

<b>Family Size</b>	<b>Yearly Income</b>	<b>Family Size</b>	<b>Yearly Income</b>
1	\$28,953	5	\$69,653
2	\$39,128	6	\$79,828
3	\$49,303	7	\$90,003
4	\$59,478	8	\$100,178

For each additional family member, add \$10,175

To apply for free or reduced-price meal benefits for your children, you must complete the attached Income Eligibility Form (IEF). Your application for free or reduced-price meal benefits cannot be approved unless the attached application is completed according to the directions provided; however, you are not required to complete the IEF. Notify the center should the household income decrease and/or if the household size increases. A participant may be eligible for free or reduced-price meals. The application is valid until the last day of the month in which the form was approved/dated/signed one year earlier.

Sincerely,

Center Owner/Director

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Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410; or
2. **fax:**  
(833) 256-1665 or (202) 690-7442; or
3. **email:**  
[Program.Intake@usda.gov](mailto:Program.Intake@usda.gov)

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MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
 COMMUNITY FOOD AND NUTRITION ASSISTANCE (CFNA)  
 CHILD AND ADULT CARE FOOD PROGRAM (CACFP)  
**INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS**

To apply for free or reduced-price meal eligibility benefits for your child(ren), please fill out this form and return it to the child care center.

**PART 1: CHILDREN ENROLLED AT THE CHILD CARE CENTER**

Complete information below for children enrolled at the center. If child(ren) are receiving Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamp) or Temporary Assistance (formerly AFDC, now funded by TANF), complete Parts 1, 3, and 4 only. Complete Parts 1, 2, 3, and 4 if you did not provide a SNAP case number or Temporary Assistance case number for all of the children listed in Part 1.

NAME (first and last)	FOSTER CHILD	BIRTH DATE	SNAP CASE NUMBER	TEMPORARY ASSISTANCE CASE NUMBER
		/ /		
		/ /		
		/ /		
		/ /		

**PART 2: HOUSEHOLD AND INCOME INFORMATION**

List all members of the household not including the children listed in Part 1. Indicate source and amount of current monthly gross income for all members of the household before deductions, such as taxes and social security. Where there are wage earners and self-employed adults, the income of the wage earner cannot be offset by the business losses of the self-employed adult. If last month's income does not accurately reflect your circumstances, you may provide a projection of your current annual income. Irregular self-employed income may be averaged over the prior 12 months. Foster children may be eligible regardless of household income. Contact the center for more information.

INCOME BASED ON (CHECK ONE)  YEARLY  MONTHLY  2 X A MONTH  EVERY 2 WEEKS  WEEKLY

HOUSEHOLD MEMBERS	GROSS WAGES	WELFARE, CHILD SUPPORT, ALIMONY	PENSIONS, RETIREMENT, SOCIAL SECURITY	OTHER

**PART 3: RACIAL ETHNIC INFORMATION (You are not required to answer this section)**

Are you of Hispanic or Latino origin?  YES  NO

What is your race? (Select one or more)

<input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE	<input type="checkbox"/> ASIAN	<input type="checkbox"/> BLACK OR AFRICAN AMERICAN	<input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	<input type="checkbox"/> WHITE
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**PART 4: SIGNATURE**

I hereby certify that all information provided is correct. I understand that this information is being given in connection with the receipt of federal funds, that institution officials may verify information, and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.

SIGNATURE OF ADULT FAMILY MEMBER	SOCIAL SECURITY NUMBER (LAST 4 DIGITS ONLY) XXX-XX-	DATE / /
PRINTED NAME OF ADULT	ADDRESS	PHONE NUMBER ( ) -

Section 9 of the National School Lunch Act requires that, unless your children's SNAP or Temporary Assistance case number is provided, you must include the last four digits of a social security number of the adult household member signing the application or indicate that the household member signing the application does not possess a social security number. Provision of the last four digits of a social security number is not mandatory, but if the last four digits of a social security number are not provided or an indication is not made that the signer has none, the application cannot be approved. The social security number may be used to identify the household member in carrying out efforts to verify the accuracy of information stated on the application. These verification efforts may be carried out through program reviews and investigations, and may include contacting employers to determine income, contacting a SNAP or welfare office to determine current certification for receipt of SNAP or Temporary Assistance benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to provide the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

**FOR CENTER USE ONLY**

TOTAL HOUSEHOLD SIZE:	INCOME:	INCOME BASED ON (CHECK ONE):	SNAP (Food Stamp)	TEMPORARY ASSISTANCE
		YEAR MONTH 2 X A MONTH EVERY 2 WEEKS WEEKLY	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		

Eligibility Determination:  Free  Reduced  Paid

SIGNATURE OF CENTER REPRESENTATIVE	DATE
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[program.intake@usda.gov](mailto:program.intake@usda.gov)

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# ELC PROGRAM FEE \$175 WEEKLY

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

School Attending: \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

DCN # \_\_\_\_\_ (if applicable)

## Payment Terms:

- Registration Fee: \$30 per family, due at registration, along with first week's tuition.
- Weekly fees are paid on Wednesday by electronic funds transfer (EFT) from a specified checking/savings account, credit or debit card for the current week of service. Should any EFT or charge not be honored, the Y will attempt to redraft the payment. If the EFT or charge is not honored on the redraft, another form of payment must be provided, plus a \$10 service charge.
- **Failure to notify the Y a week in advance of any changes to your child's schedule or enrollment will result in the bank draft being processed on the Wednesday of the current week. No refunds will be issued.**

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

## ACCOUNT ACCESS AUTHORIZATION

I authorize the following to have access to my child(ren)'s account in the event that the named person(s) is paying the account. I understand by listing the person(s), that they will have access to the account balance for my child(ren). If a person has not been authorized, information about my child(ren)'s account should not be provided.

Name: \_\_\_\_\_

Name: \_\_\_\_\_

## EXTRA CURRICULAR ACTIVITIES

I give my permission for my child \_\_\_\_\_, to participate in  
Name of Child

\_\_\_\_\_. The program will run from \_\_\_\_\_  
Name of Program Start Date

to \_\_\_\_\_, and they will meet every \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_.  
End Date Day of the Week Start Time End Time

\_\_\_\_\_ My child WILL return to the School Age Child Care program after the activity.

\_\_\_\_\_ My child WILL NOT return to the School Age Child Care program after the activity.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

# ELC BANK DRAFT FORM

School name: \_\_\_\_\_

First Name	MI	Last Name	M/F	Birth Date
Telephone	Cell	Email		

## Billing Address

Street	City	State	Zip
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## Payment Terms & Conditions on electronic signature

■ In order to provide for convenient School Age Child Care payments to the YMCA of St. Joseph, we authorize electronic funds transfer (EFT) from this specified checking/savings account, credit or debit card. We will provide a one week written notice for any changes to our account.

■ Should any EFT or charge not be honored, we understand that the Y will attempt to redraft the payment. If the EFT or charge is not honored on the redraft, we will be required provide another form of payment plus a \$10 service charge.

**Failure to notify the Y a week in advance of any changes to your child's schedule or enrollment will result in the bank draft being processed on the Wednesday of the current week. No refunds will be issued.**

## Payment Options

Electronic Funds Transfer (EFT): \$  beginning (MMYY)

A.  Checking  Savings Bank Name: \_\_\_\_\_

Account Number

Routing Number

Please attach a voided check

B. Debit/Credit Card:  Visa  MC  Discover  AMEX

Expire Date

CVV

**I have read and agree to all terms of the YMCA payment terms and conditions.**

Signature of Responsible Party	Date
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FOR YOUTH DEVELOPMENT®  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

# YMCA OF ST. JOSEPH THIRD PARTY/DFS FORM RESPONSIBILITY AGREEMENT

**This form must be signed and submitted at time of registration.**  
Only parents with third party billing of DFS/Voc Rehab need to fill out this form.

The YMCA of St. Joseph accepts payment from DFS (Division of Family Services)/Voc Rehab. It is important that you read the fee schedule so you are aware of the rates you will be charged for any YMCA services used which are not covered by your third party funding. This agreement is **REQUIRED** for all families who are subsidized by DFS/Voc Rehab, Third Party agencies, or other individuals. Please read the following carefully.

As a parent or legal guardian of **(child's name)**, I understand and agree to the following:

- I am responsible for payment of the **full weekly tuition fee, due every Wednesday (paid by EFT) for the current week of service**, until official notice of DFS/Voc Rehab qualification is received. I have read the **Parent Handbook and Fee Schedule**, including payment policies, and understand that I am responsible for any fees not covered by DFS/Voc Rehab or third party, **including the \$30 per family registration fee.**
- Initially I am responsible for **payment at the full fee for any care I use that is not authorized by DFS/Voc Rehab.**  
This includes, but is not limited to:
  1. Any care that occurs before or after the dates authorized by DFS/Voc Rehab.
  2. Care used on days/times not authorized by DFS/Voc Rehab.
  3. Late pick-up fees
  4. Late payment fees
  5. **ANY** other fees as indicated in YMCA documents including the Parent Handbook.
- I will **contact DFS/Voc Rehab and the YMCA immediately, in writing, if my situation changes (employment status, hours of work or enrollment in school, class schedule, custody issues, living arrangements, change of address).**
- I will provide my caseworker with documentation at least **two weeks before my contract expiration date.** This gives your caseworker time to process your information and provide a new authorization to the Y before your current contract expires.
- Cancellation/Expiration of DFS/Voc Rehab funds **does not automatically cancel or change** my childcare with the YMCA. **I am responsible for completing change/cancellation forms** according to YMCA policies. **If your DFS/Voc Rehab expires, you will be charged as a full paying family** until the Y receives a change/cancellation form.
- I understand that **YMCA financial assistance may be available** if I have applied, but do not qualify for DFS/Voc Rehab. Financial assistance **is not retroactive.**
- **I understand that failure to make payments as scheduled can/will result in termination of my care and will result in lack of DFS/Voc Rehab benefits for future providers. Failure to pay all fees in a timely manner may result in disenrollment from the program and your account being sent to collection.**

Expiration Date: \_\_\_\_\_

Weekly Amount due from parent \$ \_\_\_\_\_

Child's Name: \_\_\_\_\_

Program Location: \_\_\_\_\_

DCN # \_\_\_\_\_ (must have at time of registration)

Parent/Guardian Name *(please print)* \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Need proof of approval letter.

## DVN Numbers

- **Hyde - 001800028**
- **Parkway - 001800073**
- **Pickett - 001993231**
- **Oak Grove - 002487385**
- **Skaith - 003003743**
- **Mark Twain - 003077594**
- **Lake Contrary - 003109844**
- **Robidoux - 003170741**

## DOCUMENTS THAT WILL REQUIRE ELECTRONIC SIGNATURE AT TIME OF REGISTRATION

### INFORMED CONSENT AGREEMENT

- I give permission for my child to participate in activities, field trips, and swimming.
- I give permission for my child to be given CPR and First Aid treatment by qualified YMCA staff as necessary until emergency personnel arrives. In the event hospitalization is required, I give consent for my child to be taken to a hospital and to be treated by a qualified physician. I agree to assume financial responsibility for such treatment.
- I give permission for my child to be transported by emergency vehicle.
- I give permission for my child's photograph/video to be printed and/or used in promotional materials such as Facebook for the YMCA.
- I've read the Parent Handbook and agree to abide by all rules and regulations stated. All information is correct and current.
- I understand that registration is not complete unless the registration fee and the payment of the first week's tuition accompanies this form.
- I understand that these agreements are subject to updates and revisions.

### SCHOOL AGE CHILD CARE PROGRAM STATEMENTS OF UNDERSTANDING

- Payments are processed every **Wednesday** for the current week of care.
- The total cost of running a 9-month program is divided equally among 9 months. The tuition remains the same each week regardless of out of school breaks or the number of half-weeks, or school closings due to inclement weather.
- I will call to inform the Site Director when my child will not be attending on any day for which he or she is signed up.
- In the event that any of the work numbers, home numbers, or emergency contact numbers that are listed for my child(ren) should change, I will immediately inform the Site Director. I will also make sure that the emergency contacts I list for my child(ren) are aware that they may be called if I cannot be reached.
- In order to change my child(ren)'s schedule, I must provide 1 week written notice, using the Change Form, to the Director. I understand that my account must be at a zero balance before I can make any changes.
- In order for this registration to be processed in accordance with the Missouri State Licensing Department, all information requested on the following registration forms must be completed at this time.
- I may disenroll my child earlier than May with written notice (a minimum of one week prior to child's final attendance). I am responsible for payment through my child's last day.
- Credits or refunds will not be given for days missed due to illness, school closings due to inclement weather, (without 1 week's written notice), or suspensions from the program.
- A non-negotiable Late Pick-Up Fee of \$25 will be assessed for all incidents of late pick-up (defined as 6:01 p.m. or after). This fee will automatically be drafted from the bank account or credit card you have on file. Continuous late pick up may result in my child's dismissal from the program.
- A copy of my child's immunization record has been turned in with this packet.
- I understand and will adhere to the policies and procedures set forth in the School Age Child Care Program Policy and Procedures Parent Handbook

## **DOCUMENTS THAT WILL REQUIRE ELECTRONIC SIGNATURE AT TIME OF REGISTRATION**

### **PAYMENT TERMS & CONDITIONS BANK DRAFT**

- In order to provide for convenient School Age Child Care payments to the YMCA of St. Joseph, we authorize electronic funds transfer (EFT) from this specified checking/savings account, credit or debit card. We will provide a one week written notice for any changes to our account.
- Should any EFT or charge not be honored, we understand that the Y will attempt to redraft the payment. If the EFT or charge is not honored on the redraft, we will be required provide another form of payment plus a \$10 service charge.
- **Failure to notify the Y a week in advance of any changes to your child's schedule or enrollment will result in the bank draft being processed on the Wednesday of the current week. No refunds will be issued.**

### **CHILD CARE LIABILITY**

- I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I may experience or incur in connection with my participation at YMCA of St. Joseph, MO. On my behalf, I hereby release, covenant not to sue, discharge, and hold harmless YMCA of St. Joseph, MO, its employees, agents, and representatives, of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, missions, or negligence of YMCA of St. Joseph, MO, its employees, agents, and representatives.
- I represent that I have adequate insurance to cover any injury or illness I may suffer or cause while participating in this activity, or else I agree to bear the costs of such injury or illness myself. I further represent that I have no medical or physical condition which could interfere with my safety in this activity, or else I am willing to assume – and bear the costs of – all risks that may be created, directly or indirectly, by any such condition.
- In the event that I file a lawsuit, I agree to do so in the state where YMCA of St. Joseph, MO is located, and I further agree that the substantive law of that state shall apply. I agree that if any portion of this agreement is found to be void or unenforceable, the remaining portions shall remain in full force and effect.
- **I have had sufficient time to read this entire document and, should I choose to do so, consult with legal counsel prior to signing.** Also, I understand that this activity might not be made available to me or that the cost to engage in this activity would be significantly greater if I were to choose not to sign this release, and agree that the opportunity to participate at the stated cost in return for the execution of this release is a reasonable bargain.
- If I have signed a separate general waiver of liability connected to my participation at YMCA of St. Joseph, MO, I agree that the terms of that waiver are wholly incorporated into this document and that the terms of this document are incorporated into the separate general waiver.

### **SACC PARENT HANDBOOK**

I acknowledge I have received a copy of the YMCA School Age Child Care Parent Handbook. I agree to abide by the policies and procedures outlined in this handbook.