BEFORE/AFTER SCHOOL REGISTRATION CHECKLIST

Below are the required documents for a completed registration:

- ☐ Updated Physical (up to 18 months)
- ☐ Immunization Records
- ☐ Electronic Funds Transfer Form (regardless of payment method)

If your child has any medical conditions below, please attach the required documents:

- ☐ Asthma
  - ☐ Asthma Action Plan
  - ☐ Medication Consent Form
  - ☐ Letter from physician, stating an asthma action plan is not needed.
- ☐ IEP/504 Plan
- ☐ Diabetes
  - ☐ Diabetes Action Plan (if applicable)
  - ☐ Individual Health Care Form
  - ☐ Medication Consent Form
- ☐ Severe Allergy
  - ☐ Anaphylaxis Allergy Plan
  - ☐ Individual Health Care Form
  - ☐ Medication Consent Form

Staff Initials: _____ **Date:** _____

YMCA OF GREATER SPRINGFIELD
Association Offices
1500 Main Street, Springfield, MA 01115 - Suite 256
P: 413.739.6951 F: 413.747.6183

MAILING ADDRESS
PO Box 15329
Springfield, MA 01115-5329
WWW.SPRINGFIELDY.ORG

OFFICE USE ONLY
Unit ID #: _____ **Site:** _____
Program: Before only /After only or Both Start date: _____ **trans: Yes/No**
Payment Type Please circle: V, F/A, Private or EEC

YMCA OF GREATER SPRINGFIELD BEFORE & AFTER SCHOOL'S OUT PROGRAM 2023-2023 REGISTRATION FORM

Child's Name: Birthdate: Sex: M F T
Home Address: City: State: Zip Code:
Cell Phone: Home:
Who does child live with: _____ Age at Admission: _____ Does your child have an IEP/IHP/504/BIP? Yes or No
School attending in 2023-2024: Grade:
Please circle the Program registering for: Before school only After School only Both
Before School programs are only for elementary schools
I would like my child to start on please specify month and day: _____

Please indicate your child's program schedule

Before School care	Monday	Tuesday	Wednesday	Thursday	Friday
After School care	Monday	Tuesday	Wednesday	Thursday	Friday
Payment	Private	F/A	EEC	Voucher	Third Party

Note for staff pertaining to your child's wellbeing:

_____

_____

Parent/Guardian Information

Parent/Guardian Name:	Parent/Guardian Name:
Date of Birth	Date of Birth
Relationship to child	Relationship to child
Phone number	Phone number
Email	Email
Occupation	Occupation
Place of employment	Place of employment
Daytime Phone #	Daytime Phone #
Hours that you work	Hours you work

If parent cannot be reached, I authorized the following people to be contacted and pick up my child in case of an emergency

Name	Relationship to child	Phone Number

The following people are authorized to pick up my child

Name	Relationship to child	Phone Number

The following people are **UNAUTHORIZED** to pick up my child due to legal reasons

(Please supply all documents to be placed with child's file)

Name	Was document submitted

2023-2024 First Aid and Emergency Medical Consent 102 CMR 1.09(3)

I authorize staff in the school age childcare program who are trained in the basics of first aid to give my child first aid when appropriate. I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and/or to secure necessary medical treatment for my child.

If something is not applicable please put N/A do not leave blank

Child's Physician Name:
Address & Phone Number:
Child's Allergy:
Child's Medication:
Chronic Health Conditions:
Special Identifying Marks:
Concerns/Limitation
Eye Color: _____ Skin Color _____ Hair Color_____ Height_____ Weight _____ Primary Language _____

First Aid & Emergency Medical Care

Health Insurance Coverage: _____

Policy Number:_____

I certify that documentation of physical examination and immunization in accordance with public school health requirement, and lead poisoning screening in accordance with public health requirements are on file at my child's school

Waver of Liability: While it is the aim and the responsibility of the YMCA of Greater Springfield to provide your child with a safe and enjoyable experience, you must realize that participation in the YMCA program has some inherent risks. I hereby release myself and my child, out heirs, executors, and administrators, and forever discharge the YMCA of Greater Springfield, its agents, servants, representative and employee for any injury, loss, liability, damage, or cost which my child may receive/incur as a result of participation in any program/activity/service conducted and/or provided by the YMCA of Greater Springfield

Parent/Guardian Signature: _____ Date: _____

YMCA Of Greater Springfield 2023-2024 School's Out Program Authorization Form

Child's Name: _____

The following are optional; Please initial those you choose

I give permission for:

__ My child to attend all field trips to locations within walking distance to the center.

__ My child to watch movies of a rating no higher than PG.

__ Schools, Administrators or school teaching staff to access any records (enrollment forms, assessments, any medical documentation) from my child's file.

__ My child to participate in a supervised YMCA gym program.

__ My child to participate in a supervised YMCA swim program.

__ My child to be observed and interact with authorized student interns and volunteers.

__ My child to begin their homework while at the program but understand that they may not complete all their homework during program hours.

__ The YMCA to use my child's picture in the YMCA publicity and media promotions

__ The YMCA to use my child's picture inside the school building

__ The YMCA to communicate with my child's school any information that is relevant to the success of my child in both school and the YMCA School's Out program. I authorize

_____, _____, and _____ to sign/and /or review any childcare documents in my absences.

Parent Signature: _____ Date:_____

Springfield 2023-2024 School's Out Program Payment & Registration Contract

Parents enter into a contract relationship with the YMCA in which both parties agree to certain conditions in writing. Those conditions include the child's schedule and tuition rate, acceptance of the Center's policies, and support of the program.

Please INTIAL you are understanding and agreement to all the following (read carefully)

Billing

____ I understand I am responsible for payment until the day of programming which is June 21st, 2024.

____ I understand that tuition is due every Friday for the following week unless an alternate payment schedule has been set up and approved by the Education Billing Department.

____ I understand that failure to pay tuition for two weeks will result in a termination notice.

____ I understand that that I am responsible for payment regardless of my child's attendance, including extended days, full day and vacation week programs. Additionally, these days your parent fee will be higher due to extended/full day services.

____ I understand that a two-week written Notice of Withdrawal from the before or after school program is required and must ONLY be submitted to the Youth Desk prior to my child's last day.

____ I understand that I will continue to be billed and are responsible for all fees two weeks from the date the YMCA is informed of my child's intended withdrawal from the program.

____ I understand that all monies must be paid on my account for my child to be readmitted to a YMCA program.

Additional Policy

____ I understand if there are any changes in my child's wellbeing, I will update the YMCA with all information and necessary legal or medical information including medication if applicable.

____ I understand all schedule changes require one week's advance notice to the Youth Desk.

____ I understand that an administrative charge of $25 will be added to my bill if One or more changes relating to my child's schedule. This fee will be automatically withdrawn on the next billable date based on your payment schedule.

____I understand that a late fee will be charged to me for late pickups, and that I am responsible to pay in full all fees for childcare services provided to me by the YMCA.

____ I understand that failure to respond to a termination notice within a given time frame will result in termination from all YMCA Programs.

____ I understand that I have access to a copy of the YMCA of Greater Springfield School Age Policies and Procedure on the www.springfieldy.org website.

Parent signature: _____ **Date:** _____

YMCA OF GREATER SPRINGFIELD 2023-2024

TRANSPORTATION PLAN AND AUTHORIZATION [7.09(3) and 7.12(1)]

Child's Name: _____

My child will be dropped off to the before school program by:

☐ Parent Drop off

My child will arrive to school by the

☐ YMCA bus/van

My child will arrive at the after-school program by:

☐ Bus/Van for Springfield & Chicopee only

(HWRSD transportation will be provided by HWRSD school department)

☐ Parent Drop off

☐ Other_____

My child will depart from the after-school program by:

☐ Parent Pick Up

☐ Other_____

Parent Signature: _____ **Date:** _____

Electronic Funds Transfer (EFT) Release form

As stated in the Payment and Registration Contract the YMCA automatically deducts weekly childcare fees unless an alternative payment schedule is submitted. Below are the options available from the account being submitted.

By signing this agreement, you acknowledge that using a bank account may take up to three business days to post to your account. You acknowledge that weekly payments must be made prior to services rendered.

I understand that and agree to the forms and policies as stated above. I understand that if my EFT payment is returned, I will be subject to a $15 return fee per return. After two returns your childcare will be in jeopardy of termination.

Child's Name:
Child's Date of Birth:
Name on Account:
Routing Number:
Accounting Number:
Account type (please circle): Checking Savings

Payment Schedule: Please indicate your payment schedule including the next available pay date to make sure all fees are charged according to your payment schedule.

Weekly will default to Friday Unless otherwise specified:
Biweekly will default to Friday Biweekly unless otherwise specified:
Please keep in mind all payments will be set to next available payment schedule date unless other wise stated. **Please indicate which day you would want payments to begin (must be prior to services rendered)**

Parent Signature: _____ Date:_____

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members

Name of Enrolled Child(ren):

Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Part 2. Benefits: If any member of your household received SNAP or TAFDC cash assistance, provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:_____ CASE NUMBER: _____

Part 3. If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call the Child Care Sponsor at Phone #: Homeless ☐ Migrant ☐ Runaway☐

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List **only** household members with income)	**B. Gross income and how often it was received** 1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) Jane Smith	$200/weekly	$150/twice a month	$100/monthly	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City:_____ State: _____ Zip Code: _____

Last four digits of Social Security Number: _ _ _ - _ _ - _ _ _ _ ☐ I do not have a Social Security Number

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
❑ Hispanic or Latino	❑ Asian	❑ American Indian or Alaska Native
❑ Not Hispanic or Latino	❑ White	❑ Native Hawaiian or Other Pacific Islander
	❑ Black or African American	

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

Categorical Eligibility: ___ Eligibility: Free___ Reduced___ Denied___

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

Effective July 1, 2023 to June 30, 2024	
Household size	**Yearly**
1	26,973
2	36,482
3	45,991
4	55,500
5	65,009
6	74,518
7	84,027
8	93,536
Each additional person:	+9,509

Privacy Act Statement: 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 Social Security Number is 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.

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/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.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

This institution is an equal opportunity provider

SHARING INFORMATION WITH MEDICAID/CHIP

Dear Parent/Guardian:

If your children qualify for free or reduced price meals, they may also be able to get low to no cost health insurance through Medicaid or the Children's Health Insurance Program (CHIP). Children with health insurance are more likely to get regular health care and are less likely to become sick.

Because health insurance is so important to children's well-being, **the law allows us to tell Medicaid and CHIP that your children are eligible for free or reduced price meals, *unless you tell us not to***. Medicaid and CHIP only use the information to identify children who may be eligible for their programs. Program officials may contact you to offer to enroll your children in this health insurance program. Filling out the CACFP Meal Benefit Income Eligibility Forms does not automatically enroll your children in health insurance.

If you do not want us to share your information with Medicaid or CHIP, fill out the form below and send it with your Income Eligibility Form to **[address] by [date]**. (Sending in this form will not change whether your children get free or reduced price meals.).

☐ **No! I DO NOT** want information from my CACFP Meal Benefit Income Eligibility Form shared with Medicaid or the Children's Health Insurance Program.

If you checked no, fill out the form below.

Child's Name: _____

Child's Name: _____

Child's Name: _____

Child's Name: _____

Signature of Parent/Guardian: _____

Today's Date: _____

Print Your Name: _____

Address: _____

_____

For more information, you may call **[name]** at **[phone]**

Rev. ESE July 2023

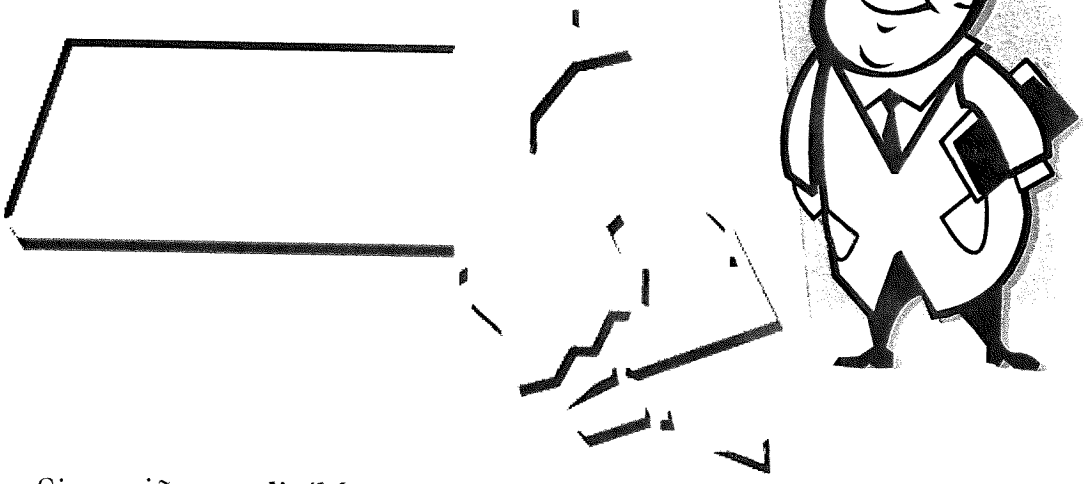
If your child is eligible for free or reduced school meals, your child may also be eligible for

free or low cost health insurance

through MassHealth.

To learn more call: 1-800-841-2900

MassHealth



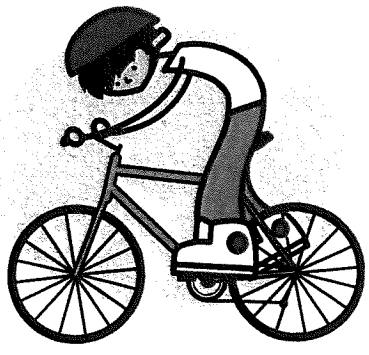
Si su niño es eligible para almuerzo gratís o reducido, su niño pueda ser eligible para

seguro de salud gratís o de bajo costo

por medio de MassHealth.

Para saber mas, llame al: 1-800-841-2900

Covering Kids



Rev. ESE July 2023