After School Enrichment Program 2018-2019

Please complete ALL forms included in this packet.

Bring this packet & the following 5 items to Friendship House to complete registration:

1. $30 Registration Fee (per family)
2. A copy of your child's most current immunizations (You can have them faxed to 259-9117)
3. Last 2 pay stubs for all members living in the household (Not required for families on Best Beginnings)
4. Most recent tax return for all members living in the household (Not required for families on Best Beginnings)
5. A copy of your child's insurance card

Packets will NOT be accepted by the front office until the entire packet is completed and accompanied documents are turned in. Enrollment is on a first come, first served basis.
AFTER SCHOOL ENRICHMENT PROGRAM
2018-2019
ENROLLMENT INFO
REGISTRATION FORM

Child's First Name: _______________  Child's Last Name: _______________

Gender:  □ MALE   □ FEMALE  Date of Birth: ___/___/____

Race (choose ONE that applies):
  □ Caucasian  □ African American
  □ American Indian or Alaska Native  □ Native Hawaiian or Other Pacific Islander
  □ Asian  □ Multi Race

Ethnicity
  □ Hispanic or Latino  □ Not Hispanic/Latino

What grade is your child enrolled in for the 2018-2019 School Year?
  □ Kindergarten  □ 1st Grade  □ 2nd Grade  □ 3rd Grade
  □ 4th Grade  □ 5th Grade  □ 6th Grade  □ 7th Grade

Current School:
  □ Orchard  □ Newman  □ Ponderosa  □ Washington
  □ Broadwater  □ Riverside  □ McKinley  □ Other: _______________
EMERGENCY CONTACT AND PARENTAL CONSENT

THIS FORM MUST BE TAKEN WITH THE CHILD WHEN EMERGENCY MEDICAL CARE IS NEEDED.

Child's Name: ___________________________ Birth Date: ________________
Address: ____________________________________________

Mother / Legal Guardian's Name: __________________ Home Number: ____________
Address: ____________________________________________
Work Address: _______________________________________

Father / Legal Guardian's Name: __________________ Home Number: ____________
Address: ____________________________________________
Work Address: _______________________________________

Emergency Contact Person: __________________ Contact Number: ____________
Emergency Contact Person: __________________ Contact Number: ____________

Physician / Medical Care Source: __________________ Contact Number: ____________

Health Insurance Carrier & Policy Number: ______________________________

Persons authorized to pick up child:
Name: ___________________________ Name: ___________________________
Name: ___________________________ Name: ___________________________

SEE REVERSE SIDE
WRITTEN CONSENT IS GIVEN FOR:

☐ Yes ☐ No  EMERGENCY MEDICAL CARE

☐ ADMINISTRATION OF PRESCRIPTION MEDICATIONS

Medication Authorization form and Medication Administration Log Must be completed

☐ ADMINISTRATION OF NON-PRESCRIPTION MEDICATIONS

OTC Medication Authorization Form and Medication Administration Log must be completed

☐ ADMINISTRATION OF SPECIAL DENTAL OR DIETARY NEEDS:

Please Specify.

☐ TRIPS:  ☐ Yes ☐ No  TRANSPORTATION BY THE FACILITY FOR TRIPS

☐ Yes ☐ No  DAILY TRANSPORTATION PROVIDED BY THE FACILITY (Facility Has the Option to Offer)

IF YOUR CHILD IS TRANSPORTED BY THE FACILITY, ARE THERE ANY INSTRUCTIONS FOR SPECIAL CARE FOR THE CHILD (I.E. MOTION SICKNESS, SEIZURES, ETC.) DURING TRANSPORTATION?

HEALTH HISTORY

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hay fever, asthma, or wheezing</td>
<td>☐</td>
</tr>
<tr>
<td>Eczema or frequent skin rashes</td>
<td>☐</td>
</tr>
<tr>
<td>Convulsions/Seizures</td>
<td>☐</td>
</tr>
<tr>
<td>Heart condition</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chickenpox</td>
<td>☐</td>
</tr>
<tr>
<td>Diabetes</td>
<td>☐</td>
</tr>
<tr>
<td>Trouble with passing urine / bowel movement</td>
<td>☐</td>
</tr>
<tr>
<td>Frequent colds, sore throats, earaches, tonsillitis, pneumonia</td>
<td>☐</td>
</tr>
</tbody>
</table>

Allergies or reaction: (food or other)

☐ Yes ☐ No

Please Explain:

Other Health Concerns (special disabilities):

☐ Yes ☐ No

Please Explain:

SIGNATURE OF PARENT OR GUARDIAN

DATE
NON-INGESTIBLE OVER THE COUNTER (OTC) MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT

Child’s Name ___________________________ Date of Birth ___/___/___
Program Name Friendship House Child Care Center Today’s Date ___/___/___

I give permission for the administration of following non-ingestible over the counter medications (mark all that apply):

☐ Diaper Rash Cream/Ointments
☐ Insect Repellent
☐ Sunscreen
☐ Cortisone/Anti-Itch Creams/Ointments
☐ Medicated Lip Treatments
☐ OTC Antibiotic Creams/Ointments
☐ Burn Creams/Sprays
☐ Other Non-Ingestible OTC’s: (Please Specify) __________________________________________

To administer a non-ingestible over the counter (OTC) medication:
- The OTC medication must be brought to the day care facility from the parent;
- The OTC medication must be in its original container, with a legible label, and expiration date of medication;
- The child’s name must be on the original container

Special handling/storage Instructions _______________________________________________________ Refrigeration Y/N

Parent/Guardian Signature (required)

* This document must be updated on an annual basis.

Unused Medication: Returned to Parent Y/N or Discarded Appropriately (circle one)

By: ____________________________________ Date ___/___/___

*Keep in the child’s file when medication is finished.
AFTER SCHOOL ENRICHMENT PROGRAM  
2018-2019 SCHOOL YEAR  

Child’s First & Last Name: ________________________________

Counseling and Other Services: Does your child currently receive services through counseling or therapy? Yes or No (circle one) If yes, please provide the name and contact information of the provider your child is currently working with:

Provider Name: ________________________________ Phone Number: ________________

General Release:
I, the undersigned (as a parent or guardian of the participant, a minor), hereby give permission for mutual exchange of information between Friendship House and the following organizations but not limited to: 21st Century After School/Summer Program, the child’s school, classroom teacher, Billings Public Schools, School District #2, Billings Catholic Schools, and all other service providers who work with their child. Information can and will be shared regarding health & safety issues, food program status, immunization records, academic achievement, and financial information. I also give Friendship House Staff authorization to communicate with all other programs in which my child is enrolled for various information such as but not limited to: income information, TANF, SNAP, health & safety issues, social & emotional issues, Best Beginnings Scholarship information, food program status, etc. Specifically, the following programs are to share with us all requested information Billings Public Schools, Billings Catholic Schools, HRDC, DPHHS, AWARE Inc., Boys & Girls Ranch, Family Service, Family Promise, MRM, private counselors, RiverStone Health, Billings Clinic, St. Vincent Healthcare, doctors, dentist, eye doctor, etc.

Initials: ____

Photo/Media Release:
For internal & external use, I acknowledge that Friendship House and the 21st Century After School/Summer Program and/or its sponsors may utilize film, print, & digital images of a student or a family, which may be taken during involvement in the Friendship House/21st Century After School/Summer Program activities. I consent to such uses & hereby waive all rights to compensation.

Initials: ____

Transportation Permission:
I hereby give my child permission to travel on the Friendship House/21st Century After School/Summer Program bus, vans, or vehicles for daily transportation to and from school and field trips. I understand that if my child is not at the designated pick up site after school, Friendship House will not be held responsible for my child under any circumstances.

Initials: ____

Parent/Guardian Signature: ________________________________ Date: ________________
AFTER SCHOOL ENRICHMENT PROGRAM
2018-2019 SCHOOL YEAR

PARENT/GUARDIAN ACKNOWLEDGEMENT
OF PARENT HANDBOOK &
TRIAL ENROLLMENT AGREEMENT

Child’s First & Last Name: ________________________________

By signing below, I/We, hereby acknowledge receipt of the Friendship House Parent Handbook.

I also understand that Friendship House is accepting my child on a month to month trial basis. A child who consistently chooses not to follow staff leadership, who is unwilling to participate in activities, abuses himself or others, or shows a generally non-cooperative attitude may be sent home for a specified period of time or removed from the program.

I understand that Friendship House reserves the right to withdraw any child from the program without reason. If the child does not show development in any area of need, Friendship House will withdraw the child from the program.

Signature: ________________________________ Date: __________
# CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

**Institution or Facility Name:**

### Part 1. Name of Child(ren) Enrolled:

<table>
<thead>
<tr>
<th>Full names of all household members</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td></td>
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<tr>
<td></td>
</tr>
</tbody>
</table>

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.

### Part 2. Benefits:

If any member of your household received [SNAP], [FPDPIR] or [TANF 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, a migrant, or a runaway, call the State agency for instructions.

### Part 4. Total Household Gross Income—You must tell us how much and how often (whole dollar amounts, please)

<table>
<thead>
<tr>
<th>Total number in household:</th>
</tr>
</thead>
</table>

#### A. Name

(List only household members with income)

(Example)

**Jane Smith**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$200/weekly</td>
<td>$150/twice a month</td>
<td>$100/monthly</td>
<td>$/</td>
</tr>
<tr>
<td>$/</td>
<td>$/</td>
<td>$/</td>
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<td>$/</td>
</tr>
</tbody>
</table>

This section required for all forms listing income in Part 4:

Last four digits of Social Security Number: _______ _______ _______ __

☐ I do not have a Social Security Number

### Part 5. Signature (Adult must sign)

An adult household member must sign this form.

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

Mark one ethnic identity:  
☐ Hispanic or Latino  
☐ Not Hispanic or Latino

Mark one or more racial identities:

☐ Asian  
☐ American Indian or Alaska Native  
☐ Black or African American  
☐ White  
☐ Native Hawaiian or Other Pacific Islander

Part 7. Decline to provide information
I choose not to provide information about my household size and income.

Signature of Adult Household Member  
Date

***This Section is to be completed by the Child Care Institution – Determination of Eligibility***

Completion of this section is required for the institution to claim meals at the free or reduced rate for the child/children listed in Part 1: Name of Child(ren) Enrolled.

Number of persons in the household:

Total income $  
Ren. ☐ Week  ☐ Every 2 Weeks  ☐ Twice A Month  ☐ Month  ☐ Year  
(Annual Income Conversion: weekly x 52, every 2 weeks x 26, twice a month x 24, monthly x 12)

Categorical Eligibility:  
☐ Free  ☐ Reduced  ☐ Paid  ☐ Tier I  ☐ Tier II

Required: Determining Official's Signature:  
Date:

Additional official signatures are recommended but not required.

Confirming Official's Signature:  
Date:

Follow-up Official's Signature:  
Date:

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), Food Distribution Program on Indian Reservations (FDPIR), or Temporary Assistance for Needy Families (TANF) case number for the participant 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.

Non-discrimination Statement: “In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.) should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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; (2) Fax: (202) 690-7442; or (3) Email: program.intake@usda.gov. This institution is an equal opportunity provider.”

Head Start: Children who are enrolled in the Federal Head Start Program receive meal benefits in the CACFP without further application or eligibility determination. Acceptable documentation includes a current approved Head Start application or a written, signed and dated statement or roster from a Head Start official. [USDA Memos CACFP 7-2008 and CACFP 10-2008]
AFTER SCHOOL ENRICHMENT PROGRAM
PAYMENT AGREEMENT
2018-2019 SCHOOL YEAR

Friendship House tuition invoices are printed the 1st week of every month. Monthly tuition is due no later than the 15th of that month. Failure to pay or make arrangements before the 15th will result in a 10% Late Payment Fee. If an arrangement has not been made, all delinquent accounts will be sent to collections after 30 days and your child(ren) will be withdrawn from the program.

All Best Beginnings Scholarship Co-Pays must be paid in full by the last business day of the month. Failure to do so may result in losing your Best Beginnings Scholarship. You will also be charged the full rate for that month (which is significantly higher than Best Beginnings Scholarship Co-Pay).

Friendship House requires ALL families to pay monthly tuition through ACH Automatic Withdrawal from your credit, debit, checking or savings account. Please fill out the attached form with your banking information completed.

Child’s First & Last Name: ____________________________________________

Responsible Payer’s First & Last Name: _________________________________________

Please select your Tuition Type:

○ State Rate: $5.73/hr. or $30.56/day

○ Best Beginnings Scholarship through HRDC
  Please provide your HRDC Caseworkers name: __________________________

○ Friendship House Scholarship (must apply & qualify)

By signing below, I am responsible for paying monthly tuition to Friendship House and abide by the terms listed above. I understand that if I do not make my payment, my child will be exited from the program and my account will be turned over to collections.

Payer Signature: _______________________________ Date: _______________________

Payer Name Printed: ____________________________________________________________
We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) Friendship House of Christian Service to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

Date you would like your tuition pulled (monthly)________________________

SECTION A (Credit Card)

Cardholder Name______________________Phone #:______________________

Cardholder Address____________________City______________________State______Zip______

Account Number______________________Expiration Date____________________

Cardholder Signature___________________Date______________________

SECTION B (Bank Account)

Your Name______________________Phone #:______________________

Address______________________City______________________State______Zip______

Bank or Credit Union Name______________________Bank or Credit Union Address______________________City______________________State______Zip______

Routing Transit Number (see sample below)______________________Account Number (see sample below)______________________

☐ Checking ☐ Savings

Authorized Signature______________________Date______________________

For Official Use Only

Date Received______________________Employee Signature______________________

Attach Voided Check Here ________________________

Deposit slips not accepted ________________________

$______________________Dollars ________________________
**PARENT CONSENT FOR MUTUAL EXCHANGE OF INFORMATION**  
(Authorization to Disclose Personally Identifiable or Health Care Information)

<table>
<thead>
<tr>
<th>ID#</th>
<th>School:</th>
<th>Student's Name:</th>
<th>Birthdate:</th>
</tr>
</thead>
</table>

I hereby give permission for the mutual exchange of information and the following records of the above student. This release is for the following records or information:

| ☑ ALL Records | ☐ Discipline Records | ☐ On-Going Program Coordination |
| ☐ Cumulative Records | ☐ Special Education Records | ☐ Other (specify) |

| ☐ Medical Records (Specify below) | ☐ Complete Medical Record | ☐ Specialist Reports | ☐ Check-Ups |
| ☐ Immunizations | ☐ Newborn Birth Records | ☐ Contagious Diseases |
| ☐ Height and Weight | ☐ Newborn Audiology |

Unless otherwise revoked, this authorization will expire on:

| ☐ Once the information is received | ☑ On-going until mutual services are discontinued |
| ☐ One year from the authorized date below | ☐ Other: |

This release is between Billings Public Schools and the following agencies and/or individuals:

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friendship House of Christian Service</td>
<td>3123 8th Ave. S. Billings MT 59101</td>
</tr>
</tbody>
</table>

Please send records (if different from the above address) to:

<table>
<thead>
<tr>
<th>School:</th>
<th>School Address:</th>
<th>Attention:</th>
</tr>
</thead>
</table>

My signature authorizes the exchange of the above information and/or records. You have the right to revoke this disclosure at anytime prior to the exchange. That request must be in writing to the building/program administrator. The district will protect all student records following federal and state guidelines. A covered entity under HIPAA may not condition treatment, payment, enrollment or eligibility upon whether you sign this authorization. Not all agencies or individuals to whom we release information to have the same federal and state law requirements and the released information may be disclosed and not protected.

Relationship to Child/Student: ____________________________

Purpose of the Release: ________________________________

Do you Request a copy of the records disclosed (at parent expense)?

☐ Yes ☑ No

SIGNATURE ____________________________ Date ___________

Records were requested by: ____________________________ Records were requested on: ____________

RecordRelease.3rdParty_022713
FRIENDSHIP HOUSE
COUNSELING SERVICES
INFORMED CONSENT FORM

FRIENDSHIP HOUSE COUNSELING is a confidential service to assist children, parents and families with mental health/mentual wellbeing concerns come to a greater understanding, and learn effective child, parent and family coping strategies to assist in better daily living. Counseling involves a relationship between the child, parent, family and our licensed clinical professional counselor who has the training, desire and willingness to help accomplish identified goals. Counseling involves teaching about mental wellbeing; intervening in problem behavior which impairs healthy development; building personal strengths; working as a team to insure positive coping skills in school, with peers and family members; and assist in connecting to community resources that may be appropriate. While counseling, there may be periods of increased anxiety or confusion. The outcome of counseling is often positive; however, the level of satisfaction for any individual is not predictable. Your counselor is available to support you throughout the counseling process.

CONFIDENTIALITY:

All interactions with Counseling Services, including scheduling of or attendance at appointments, content of your sessions, progress in counseling, and your records are confidential. No record of counseling is contained in any academic or educational file. You may request in writing that the counseling staff release specific information about your counseling to persons you designate.

EXCEPTIONS TO CONFIDENTIALITY:

• The counseling staff works as a team with Friendship House team members. Your counselor may consult with Friendship House staff to provide the best possible care.

• If there is evidence of clear and imminent danger of harm to self and/or others, a counselor is legally required to report this information to the authorities responsible for ensuring safety.

• Montana state law requires that staff of Counseling Services who learn of, or strongly suspect, physical or sexual abuse or neglect of any person under 18 years of age must report this information to county child protection services.

• A court order, issued by a judge, may require the Counseling Services staff to release information contained in records and/or require a counselor to testify in a court hearing.

Fees for Friendship House Counseling services are processed with your family health insurance; however, counseling services will not result in any additional cost to you beyond your program fees.

I have read above information and understand it. I will contact Friendship House's Counseling Team if I have questions or concerns. I understand the risks and benefits of counseling, the nature and limits of confidentiality, and what is expected of me as a client of the Counseling Services or a parent/guardian of a counselee.

Printed Name of Client(s) (child(ren))

Signature of Therapist

Printed name of Parent/Guardian

Signature of Parent

Date
FRIENDSHIP HOUSE – PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for trusting Friendship House Counseling to provide mental health services. We are committed to providing you with the highest quality care. We ask that you read and sign this form to acknowledge your understanding of our financial responsibilities policies.

- Patient Financial Responsibilities Includes
- The child (or child’s guardian) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, you will need to provide the most correct and updated information regarding insurance.
- Friendship House will bill your insurance and accept for payment whatever the insurer provides. There will be no additional costs to you.
- By my signature below, I hereby authorize assignment of financial benefits directly to Friendship House and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form

______________________________  ____________________________
Parent/Guardian Signature            Date

______________________________
Child/ren Names
IMMUNIZATION REQUIREMENTS

Friendship House is a Licensed Child Care Center through the State of Montana. Children that do not have proof of current immunizations will not be enrolled at Friendship House.

The State of Montana states: Before a child age 4 – 12 may attend a Montana Child Care Facility, that facility must be provided with the documentation showing that the child has been immunized as required for the child's age group against measles, mumps, rubella, poliomyelitis, diphtheria, pertussis, tetanus, and haemophilus influenza type B.

<table>
<thead>
<tr>
<th>Vaccines</th>
<th># of Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varicella</td>
<td>2 doses by Kindergarten</td>
</tr>
<tr>
<td>Polio</td>
<td>3 doses</td>
</tr>
<tr>
<td>DTP</td>
<td>4 doses</td>
</tr>
<tr>
<td>MMR</td>
<td>2 doses</td>
</tr>
<tr>
<td>HIB</td>
<td>1-4 (depending on vaccine type)</td>
</tr>
</tbody>
</table>

Immunizations are easily obtained by your child's doctor's office or school. You can have them faxed to Friendship House at 259-9117