Summer Enrichment Program 2020

Please complete ALL forms included in this packet.

* Bring this packet & the following items to Friendship House to complete registration:
  * Bill paid in full from previous enrollment
  * $30 (exact change) Registration Fee per family
  * A copy of your child’s current immunizations. You can have them faxed to 259-9117.
  * Your child’s private insurance/Medicaid 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.

Friendship House of Christian Service
3123 8th Ave South Billings, MT 59101
(406)259-5569
SUMMER ENRICHMENT PROGRAM
ENROLLMENT INFO
REGISTRATION FORM

Child's First Name: ________________  Child's Last Name: ________________

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

Race/Ethnicity (choose all that apply):

□ Caucasian  □ Hispanic or Latino  □ African American

□ American Indian  □ Native Hawaiian or Other Pacific Islander

□ Asian  □ Mixed Ethnicity

What grade was your child enrolled in for the 2019-2020 School Year?

□ Preschool  □ Kindergarten  □ 1st Grade  □ 2nd Grade  □ 3rd Grade

□ 4th Grade  □ 5th Grade  □ 6th Grade  □ 7th Grade

Current School:

□ Orchard  □ Newman  □ Ponderosa  □ Washington

□ Broadwater  □ Riverside (6th Grade) □ McKinley  □ Other:__________
# EMERGENCY CONTACT AND PARENTAL CONSENT

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

<table>
<thead>
<tr>
<th>Child’s Name:</th>
<th>Birth Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mother / Legal Guardian’s Name:</th>
<th>Home Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Cell Number:</td>
</tr>
<tr>
<td>Work Address:</td>
<td>Work Number:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Father / Legal Guardian’s Name:</th>
<th>Home Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Cell Number:</td>
</tr>
<tr>
<td>Work Address:</td>
<td>Work Number:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Contact Person:</th>
<th>Contact Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Contact Person:</td>
<td>Contact Number:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician / Medical Care Source:</th>
<th>Contact Number:</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Health Insurance Carrier &amp; Policy Number:</th>
</tr>
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</table>

**Persons authorized to pick up child:**

<table>
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<tr>
<th>Name:</th>
<th>Name:</th>
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<table>
<thead>
<tr>
<th>Name:</th>
<th>Name:</th>
</tr>
</thead>
</table>

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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>Condition</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hay fever, asthma, or wheezing</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Eczema or frequent skin rashes</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Convulsions/Seizures</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Heart condition</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Chickenpox</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Diabetes</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Trouble with passing urine/ bowel movement</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Frequent colds, sore throats, earaches, tonsillitis, pneumonia</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

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Allergies or reaction: (food or other) ☐ ☐

Please Explain:

---

Other Health Concerns (special disabilities): ☐ ☐

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 ___________________________ 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.
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 may attend a Montana day 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, rubella, mumps, poliomyelitis, diphtheria, pertussis (whooping cough), tetanus, varicella, hepatitis B, pneumococcal, and Haemophilus influenza type B.

<table>
<thead>
<tr>
<th>Vaccines</th>
<th># of Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP</td>
<td>4 doses</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>3 doses</td>
</tr>
<tr>
<td>Hib</td>
<td>3-4 doses (depending on vaccine type)</td>
</tr>
<tr>
<td>Polio</td>
<td>3 doses</td>
</tr>
<tr>
<td>PCV</td>
<td>4 doses (not required after 5 years of age)</td>
</tr>
<tr>
<td>MMR</td>
<td>1 dose (2nd by Kindergarten)</td>
</tr>
<tr>
<td>Varicella</td>
<td>2 dose (2nd by Kindergarten)</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
FRIENDSHIP HOUSE COUNSELING SERVICES
INFORMED CONSENT FORM

FRIENDSHIP HOUSE COUNSELING is a confidential service to assist children, parents and families with mental health/mental 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 Child

______________________________

Signature of Therapist

Printed name of Parent/Guardian

______________________________

Signature of Parent

Date

6/18
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 Name
NEW STUDENT FORM

HOW CAN WE WORK TOGETHER FOR YOUR CHILD’S CONTINUED GROWTH AT FRIENDSHIP HOUSE

Date: ______________________   Child’s name (please print): ______________________

1. Is your child aware of rules and the need for safety? If not, please explain.

2. Does your child have good problem-solving skills? If not, please explain.

3. Does your child have good communication skills? If not please explain.

4. Does your child have any issues with paying attention? If so, please explain.

5. Is your child able to re-direct when you ask them to change their behavior? If so, please explain.

6. Does your child have good coping skills when they are anxious or upset? If so, please explain.

7. Does your child have any behaviors which concern you currently? If so, please explain.
RETURNING STUDENT FORM

HOW CAN WE WORK TOGETHER FOR YOUR CHILD’S CONTINUED GROWTH
AT FRIENDSHIP HOUSE

Date: ___________________ Child’s name (Please Print) __________________________

PLEASE CIRCLE ONE OF THE ANSWERS UNDER EACH QUESTION.

1. Are there challenges you notice in your child having age appropriate safe
   behaviors/being able to talk about the reasons for rules?
   Seldom   Occasionally   About average for age   A bit of a concern   Some difficulties

2. Are there challenges you notice in your child being able to manage age appropriate
   problem solving?
   Seldom   Occasionally   About average for age   A bit of a concern   Some difficulties

3. Are there challenges you notice in your child’s age appropriate listening and
   communication progressing forward being thoughtful/respectful?
   Seldom   Occasionally   About average for age   A bit of a concern   Some difficulties

4. Are there age appropriate challenges you notice in your child being able to receive
   feedback and accept/use it to adapt behaviors?
   Seldom   Occasionally   About average for age   A bit of a concern   Some difficulties

5. Are there age appropriate challenges you notice in your child being able to identify/
   manage emotional ups and downs?
   Seldom   Occasionally   About average for age   A bit of a concern   Some difficulties
Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. This child care center offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture’s (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached Meal Benefit Income Eligibility Form. In addition, by filling out this form, we will be able to determine if your child(ren) qualifies for free or reduced price meals.

1. Do I need to fill out a Meal Benefit Form for each of my children in child care? You may complete and submit one CACFP Meal Benefit Income Eligibility Form for all children enrolled in child care in your household only if the children in child care are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. Return the completed form to your child care center.

2. Who can get free meals without providing income information? Children in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Food Distribution Program on Indian Reservations (FDPIR), or Temporary Assistance for Needy Families (TANF) can get free meals. Foster children and children enrolled in Head Start are also eligible for free meals.

3. Who can get reduced price meals? Your children can get low cost meals if your household income is within the reduced price limits on the Federal Income Eligibility Guidelines.

4. May I fill out a form if someone in my household is not a U.S. citizen? Yes. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center.

5. Who should I include as members of my household? You must include everyone in your household (such as grandparents, other relatives, or friends who live with you) who shares income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you.

6. How do I report income information and changes in employment status? The income you report must be the total gross income listed by source for each household member received last month. If last month’s income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month’s income as a basis to make this projection. If your household’s income is equal to or less than the amounts indicated for your household’s size on the Income Eligibility Guidelines chart, the center will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or by providing a current SNAP, FDPIR, or TANF case number, you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the eligibility standards.

7. What if my income is not always the same? List the amount that you normally get. For example, if you normally get $1000 each month, but you missed some work last month and only got $900, put down that you get $1000 per month. If you normally get overtime, include it, but not if you only get it sometimes.

8. What if I have foster children? Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the Meal Benefit Form, but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children should contact your child care center director.

9. We are in the military, do we include our housing and supplemental allowances as income? If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member’s income made available by them or on their
behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

10. (Pricing program only) Will the information I give be verified? Maybe. We may ask you to send written proof to verify the information you submitted on the form. What if I disagree with the decision about the information I complete on this form? You should talk to your child care center.

In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex, age or disability.

If you have other questions or need help, call your child care center.

Sincerely,
INSTRUCTIONS FOR COMPLETING THE CACFP
MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Follow these instructions, if your household gets SNAP, FDPIR or TANF:
Part 1: List all enrolled children and household members.
Part 2: List the casc number for any household members (including adults) receiving [SNAP], [FDPIR] or [TANF] benefits.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. The last four digits of a Social Security Number are not necessary.
Part 6: Answer this question if you choose.
Part 7: Skip this part.

If you are applying only on behalf of a foster child, follow these instructions:
If all children you are applying for are foster children, or if you are only applying for benefits for the foster child:
Part 1: List all foster children. Check the box indicating that the child is a foster child.
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. A Social Security Number is not necessary.
Part 6: Answer this question if you choose.
Part 7: Skip this part.

If some of the children in the household are foster children:
Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income" box. Check the box if the child is a foster child.
Part 2: If the household does not have a case number, skip this part.
Part 3: If any child you are applying for is homeless, migrant, or a runaway, call the State agency for instructions.
Part 4: Follow these instructions to report total household income from this month or last month.
   Column A – Name: List only the first and last name of each person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.
   Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly. If no income, please write a zero.
   Box 1: List the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your pay stub or your boss can tell you.
   Box 2: List the amount each person got for the month from welfare, child support, and alimony.
   Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran’s (VA) benefits, disability benefits.
   Box 4: List ALL OTHER INCOME SOURCES including Worker’s Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, report income after expenses in Box 1. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.
Part 5: Adult household member must sign the form and list the last four digits of his/her Social Security Number or mark the box if s/he doesn’t have one.
Part 6: Answer this question if you choose.
Part 7: Sign here if you choose not to provide household size and income information.
ALL OTHER HOUSEHOLDS, follow these instructions:

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box."

Part 2: Skip this part.

Part 3: If any child you are applying for is homeless, migrant, or a runaway, call the State agency for instructions.

Part 4: Follow these instructions to report total household income from this month or last month.

Column A – Name: List only the first and last name of each person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your pay stub or your boss can tell you.

Box 2: List the amount each person got for the month from welfare, child support, and alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran’s (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker’s Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, report income after expenses in Box 1. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of his/her Social Security Number or mark the box if s/he doesn’t have one.

Part 6: Answer this question if you choose.

Part 7: Sign here if you choose not to provide household size and income information.

Privacy Act Statement: This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.
**CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)**

**Institution or Facility Name:**

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

CHECK THE BOX NEXT TO THE CHILD'S NAME IF THEY ARE A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT).

Full names of all household members

**Part 2. Benefits:** If any member of your household received [SNAP], [FDPIR] 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>A. Name (List only household members with income)</th>
<th>B. Gross income and how often it was received (if $0, please write $0. Any field left blank will be accepted as representative of &quot;no income&quot;)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Frequency</th>
<th>Frequency</th>
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<tr>
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</tbody>
</table>

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

Last four digits of Social Security Number: X X X X - X -

☐ 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:  Mark one or more racial identities:

☐ Hispanic or Latino  ☐ Asian  ☐ American Indian or Alaska Native  ☐ Black or African American
☐ Not Hispanic or Latino  ☐ 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 $_________ Per: ☐ 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: ________________

Confirming 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 sign 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 laws and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, 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. 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]
BEST BEGINNINGS CHILD CARE SCHOLARSHIP

ATTACHMENT C

CHILD CARE SERVICE PLAN

INSTRUCTIONS: WE NEED CHILD AUTHORIZED AT BOTH SITES IN CASE GROUPS MOVE.

When you select a child care provider, the Child Care Resource and Referral (CCR&R) agency needs the information below to complete the child care authorization plan.

- Use a separate form for each child care provider.
- If you change providers, submit a new form before, or within one (1) business day to maintain a child care scholarship.

Payment is not issued until your child care authorization plan is complete. You and your provider will receive a copy of the authorization plan in the mail. The authorization plan shows the date span and child care hours each child is approved for.

This is not an application for a child care scholarship. This is not a contract. This information is used only to arrange for a child care scholarship. The parent and provider may contract for services in a separate agreement.

1. APPLICANT INFORMATION

<table>
<thead>
<tr>
<th>APPLICANT NAME</th>
<th>PHONE #</th>
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<th>ADDRESS</th>
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</table>

2. PROVIDER INFORMATION (Ask your provider to help you in completing this form)

A provider must have a current payment (PV) number.

<table>
<thead>
<tr>
<th>PROVIDER’S NAME</th>
<th>PROVIDER’S LICENSE #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friendship House Child Care Center</td>
<td>PV# 76060</td>
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<table>
<thead>
<tr>
<th>PROVIDER’S ADDRESS</th>
<th>PROVIDER’S TELEPHONE #</th>
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</thead>
<tbody>
<tr>
<td>3123 8th Avenue South, Billings MT 59101</td>
<td>259-5569</td>
</tr>
</tbody>
</table>

Type of Child Care Setting/Facility:

- [ ] FFN - Family, Friend, and Neighbor OR [ ] RCE - Relative Care Provider Exempt
  - [ ] Parent Home or [ ] Provider Home

- [ ] Family Child Care Home
- [ ] Group Child Care Home
- [ ] Child Care Center

<table>
<thead>
<tr>
<th>CCR&amp;R OFFICE USE ONLY</th>
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<tr>
<td>CS: Begin Date</td>
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</table>
### 3. CHILD 1 SCHEDULE

<table>
<thead>
<tr>
<th>Child's Name:</th>
<th>Provider's Name: Friendship House Child Care Center</th>
<th>Start Date</th>
</tr>
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</table>

**Is this child related to the provider?**  ☐ Yes ☐ No  If yes, relationship

**Is this the Child's Primary Provider?**  ☐ Yes ☐ No

**HOURS AND DAYS CHILD CARE IS PROVIDED**

<table>
<thead>
<tr>
<th>SUNDAY</th>
<th>MONDAY</th>
<th>TUESDAY</th>
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**Hrs per day**

**The above schedule remains the same for the entire month.**

**The above schedule varies throughout the month.**

If schedule varies, please explain:

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### 4. CHILD 2 SCHEDULE

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<tr>
<th>Child's Name:</th>
<th>Provider's Name: Friendship House Child Care Center</th>
<th>Start Date</th>
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BEST BEGINNINGS CHILD CARE SCHOLARSHIP
ATTACHMENT C
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<tbody>
<tr>
<td>Friendship House Orchard Site</td>
<td>PV# 107389</td>
<td>200-5940</td>
</tr>
<tr>
<td>PROVIDER’S ADDRESS</td>
<td>120 Jackson Street, Billings MT 59101</td>
<td></td>
</tr>
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Type of Child Care Setting/Facility:

- [ ] FFN - Family, Friend, and Neighbor
- [ ] RCE - Relative Care Provider Exempt
  - [ ] Parent Home
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<th>CS Begin Date</th>
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<th>Reason</th>
<th>Determination Date</th>
<th>Date Received</th>
<th>Determined By</th>
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ATTACHMENT C: Child Care Service Plan: DPHHS-HCS/CC-015 (rev 12/18)
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#### HOURS AND DAYS CHILD CARE IS PROVIDED

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SUMMER ENRICHMENT PROGRAM 2020 Release Form

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: ______________________

What is your child’s counseling schedule: (example: every other Monday)

______________________________

General Release: I, the undersigned (as a parent or guardian of the participant, a minor), hereby give permission for mutual exchange of information between 21st Century After School/Summer Program, Friendship House, and the child’s school and classroom teacher regarding health & safety issues, food program status, immunization records, and academic achievement. I also give Friendship House Staff authorization to communicate with other programs such as but not limited to: Billings Public Schools, Billings Catholic Schools, HRDC, AWARE Inc., Boys & Girls Ranch, Family Service, Family Promise, private counselors, doctors, etc.

Signature: ________________________________

Photo/Media Release: For internal & external use, I acknowledge that 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 21st Century After School/Summer Program activities. I consent to such uses & hereby waive all rights to compensation.

Signature: ________________________________

Transportation Permission: I hereby give my child permission to travel on the 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.

Signature: ________________________________

Parent/Guardian First & Last Name (printed): ______________________ Date: ______________
Payment Agreement Form 2020 Summer

Friendship House tuition invoices are printed at the beginning of every month. Responsible payers must make sure monies are available for your chosen pull date from the 6th-26th of the month. Failure to pay or make arrangements before your pull date 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 exited from the program.

We require that students attend Friendship House programs a minimum of three days a week and at least six hours a day. We require that you notify the Friendship House Front Office if your child will be absent by 10AM on the day of absence. Failure to inform FH of your child’s absence will result in a $5.00/day/child charge on your account.

Friendship House has a $30.00 Non-refundable REGISTRATION fee per family. This MUST be paid at time of registration.

All Co-Pays for the HRDC Best Beginnings Scholarship must be paid in full by the last day of the month. Failure to do so will result in closure of your Best Beginnings Scholarship. You will also be charged the State Daycare Rates to cover our administrative reimbursement fee for that month (which is significantly higher than Best Beginnings Scholarship Co-Pay).

Child’s First & Last Name: __________________________

Responsible Payer’s First & Last Name: __________________________

- $26.25 (over 6 hours per day) or $13.13 (0-6 hours per day) for children 6 years and older.
- OR $35.00 (over 6 hours per day) or $17.50 (0-6 hours per day) for children under 6 years.
  These rates are subject to change depending on state childcare rates.
  Written notification will be provided in the event of a rate change.

- Best Beginnings Scholarship through HRDC

Please provide your HRDC Caseworker Name: __________________________

- Friendship House Scholarship (must apply & qualify)$_____

w/ FH scholarship you will be required to complete parent service hours at Friendship House.

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: __________________________

FH Admin Signature: __________________________ Date: ____________
We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, real-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**

We hereby authorize (business name) **FRIENDSHIP HOUSE OF CHRISTIAN SERVICE** to initiate credit card charges to a below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, as 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. Please contact the center for accepted credit card types.

Choose a pull date from the 6th of the month to the 26th.

Complete one section only.

**SECTION A (Credit Card)**

- Holder Name
- Phone #
- Holder Address
- City State Zip
- Account Number
- Expiration Date
- Holder Signature
- Date

**SECTION B (Bank Account)**

- Account Holder Name
- Phone #
- Address
- City State Zip
- Account or Credit Union Name
- Bank or Credit Union Address
- City State Zip
- Checking Savings
- Routing Transit Number (see sample below)

Authorized Signature

**Official Use Only**

Date

Attach Vested Check Here

Deposit slips not accepted

**Procare Software**

A service of...