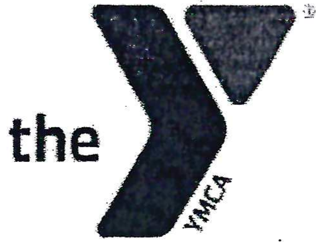

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Primetime YMCA OF TOPEKA

2023-2024

Primetime- The Y's before and after school program employs mission oriented team members who are active engaging and responsible to work with our children. Based in area Elementary schools, students in grades K-6 are nurtured in a comfortable, thought-provoking child care environment. Primetime is **NOT a DROP-IN** program, child must be enrolled for days care needed.

Primetime-Sites are open Before school @ 7am
After school until 6pm

Lowman Hill
Berryton
Shawnee Heights Elementary

AM- $ 10.00 /day
PM- $ 15.00/day
AM & PM- $ 25.00/day
Terry Jones-785-435-8651- Director – terryj@ymcatopeka.org
Toni Colon – Billing Questions - tonic@ymcatopeka.org

Extended Camp – School Day Out Camp- This program offers daily Childcare options for elementary aged students during school days out such as teacher in-service days etc. The program is @ the Southwest YMCA(students K-6th) students needs are balanced with Learning, physical activities and social skills.

7:00 am – 6:00 pm @ Southwest YMCA – 3635 SW Chelsea Dr
Members: 27.00/day
Non-Members: 30.00/day

Enrollment form needs to be submitted prior to child attending form can be dropped off @ YMCA or emailed: tonic@ymcatopeka.org

Form can be found @ www.ymcatopeka.org

School Age Program

YMCA PRIME TIME-BEFORE & AFTER SCHOOL CARE
2023-2024 Enrollment Forms (Please Print) **Account #**

SCHOOL (<u>Please Circle One</u>):

Lowman Hill **Shawnee Heights Elementary**
Berryton

Start Date: ___/___/___

<u>Primetime ONLY:</u>
Please circle session attending: AM - PM - Both | **Days of Week: M T W Th F**

Child's Name:	Date of Birth:__/__/__ Male or Female	Age:	Grade in Fall of 2020:
Child's Address:	City/State/Zip:		

Primary Parent/Guardian Contact Information __Mother __Father __Other:____________________

Primary Parent/Guardian Name:	Date of Birth:__/__/__ Male or Female	Cell# Home# Work#
Home Address (if different from child):	City/State/Zip:	
Custodial Parent: __Yes __No	May the Y release to non custodial Parent? __Yes __No	
Ethnicity: __Caucasian __African American __Hispanic __Asian/Pacific Islander __Other____________________		
Email:	Preferred Method of Communication: __Email __Phone __Text __All	

Primary Parent/Guardian Contact Information __Mother __Father __Other:____________________

Primary Parent/Guardian Name:	Date of Birth:__/__/__ Male or Female	Cell# Home# Work#
Home Address (if different from child):	City/State/Zip:	
Custodial Parent: __Yes __No	May the Y release to non custodial Parent? __Yes __No	
Ethnicity: __Caucasian __African American __Hispanic __Asian/Pacific Islander __Other____________________		
Email:	Preferred Method of Communication: __Email __Phone __Text __All	

Emergency Contact/Authorized Pick Up (other than parents):

Name:	Home Address:	City/State/Zip:
Relationship to Child:	Phone #:	Driver's License:

Additional Authorized Pick Up (other than parents):

Name:	Address:	Phone #:
Name:	Address:	Phone #:
Name:	Address:	Phone #:

Date:___________ Initials:_________

YMCA Program Payment Agreement

Initials **Accounting Policies:**

____ 1. Acceptable payment form is: Scheduled payment by Electronic Funds Transfer (EFT) or credit card. Pay in full by cash, check or credit card.

____ 2. Drafts will be made on Friday for the following week of primetime & kid's club. **Drafts will be made each week unless two-week written notification** has been provided for cancellation.

____ 3. The Y does not issue statements for individual tax purposes. Please keep any and all cancelled checks, payment receipts or bank statements as documentation of childcare payments.

____ 4. No adjustments in the weekly fee will be made for partially attended weeks.

____ 5. If your payment is returned for insufficient funds (NSF), your payment along with an NSF service fee of $30 will be collected electronically. Any change to your billing information must be received at least seven days prior to the date the change is to take effect. A $10 late fee will be assessed on payments not made by the deadline.

____ 6. If full payment arrangement is not received, I understand that my child will be considered unregistered for primetime and will not be able to attend until the arrangement is received.

Payment Information:

Parent's Name:________________________________ **DOB:**__________________
Child's Name:________________________________ **DOB:**__________________
Child's Name:________________________________ **DOB:**__________________

____ I will make advanced payment in full at the YMCA Front Desk at the time of registration
____ I will be paying with electronic funds transfer. Information below is required with a voided check:
Bank Name:______________________________ Bank City/State________________________
Type of Account: ____ Checking ____ Savings
Print your name as it appears on the account:____
Bank Routing Number:_______________________ Account Number:____________________
____ I will be paying with a Credit Card: __Visa ___MasterCard ___Discover ___American Express
Card Number:__________________________ Expiration Date:__________ 3-Digit Code:_____
Print name as is appears on card:_____________________________ Zip Code:___________
____ I receive third party payments, i.e. DCF/SRS, KVC, (Must have DCF/SRS/KVC approval letter prior to attend) I understand that I am responsible for all copayment. Fees and payments will not be determined by time sheets.

We have read the Accounting Policies and agree to comply with all payments and policies.

____________________	____________________	____________
Responsible Party for Bill	**Signature**	**Date**
Email	**Phone #**	
Print Name of Authorized Signature	**Authorized Signature**	**Date**

Participant Health History and Information

Hospital preference (circle one): St. Francis Stormont Vail Other ____________________

Child's Doctor:______________________________Address:______________________________Phone#:______________

Is your child covered by insurance? __Yes __ No If yes please complete the following:

Health Insurance/Medical Assistance Name______________________________ Policy/Card number ______________

Military Medical Care I.D. Number______________________________________

Check any conditions that your child has experienced:

__Asthma __Autism __Diabetes __Heart/Lung Conditions __ADD/ADHD __Cerebral Palsy/Other Motor Disorder

__Cognitive or Learning Disabilities __Status of Vision, Hearing, Speech to Note______________________________

__Non-Food Allergies (list)____

__Food/Milk Allergies (list)____

If your child has food allergies or dietary restrictions, attach a statement from a medical professional. (REQUIRED)

__My child carries an epi-pen, inhaler or other medication. (additional medication form is required)

__Other conditions to note:____

Please provide symptoms and/or special instructions for any condition marked above. (Additional form is required and notes may be attached)____

Check any of the following that relate to your child:

__Fears we should be aware of: ____

__An event in your child's life that may have been particularly upsetting: ______________________________

__Social or emotional characteristic you would like to note: ______________________________________

Other conditions requiring special care or additional information you feel would be helpful. (additional pages or notes may be attached)____

Please answer yes/no to each of the following:

____My child attended a public/accredited non-public school in Kansas, Missouri, or Oklahoma the previous year.

_____I have provided a copy of immunization records for my kindergarten child along with this form.

_____My child is current on his/her immunizations.

Is your child currently taking any medication during prime time? __Yes __No If yes, what kind and why (unless confidential by law)? ____If any medication (prescription or over the counter) is required during Y program time, a medication form **MUST** be completed.

The YMCA of Topeka has my permission to: (initial each line)

_____ Involve my child in swimming

_____ Involve my child in field trips

_____ Involve my child in photographs or video taken for Y publicity purposes

_____ Transport my child, provided that the Y and the driver have the legally required insurance in force, the driver has a valid Kansas driver's license and there is a current Kansas tag on the vehicle.

Statement of understanding: (your signature confirms your agreement with the following terms)

- I will notify the staff of any changes in the registration information.
- I understand it is my responsibility to sign my child in upon arrival to the program and out before leaving each day.
- I understand there is $1/minute late pick up fee charged for each child picked up after 6pm. If the child is not picked up by 7:00pm 911 will be called.
- I understand that the Y has a no outside contact policy between Staff and Children. This includes but is not limited to: babysitting, sleepovers, transportation or other non-Y events.
- I understand that state law mandates the Y to report any suspected cases of child abuse or neglect to the appropriate authorities for investigation.
- **In the event that I cannot be reached to make arrangements for emergency medical attention at the time of illness or accident, I hereby authorize the Y to take my child to the nearest facility for medical attention.**
- I consent to my child's participation in the Y program and assume the risks involved. I attest and verify that I have knowledge of the risks involved in program activities and I give my child authorization to participate in such activities.
- By signature and of free will I do hereby agree to indemnify and hold harmless the Y for any and all claims or demands, cost of expense arising out of any injury or damage sustained by me or any party I am responsible for.
- I understand that even when every reasonable precaution is taken, accidents can sometimes happen. Therefore, in exchange for allowing my child to participate in Y programs, I understand and expressly acknowledge that I, for myself and for anyone entitled to act on my behalf, waive and release the Y, sponsors, representatives and successors from all claims or liabilities of any kind arising out of my child's participation in activities at or sponsored by the Y. I further agree to indemnify and save harmless the Y from any claims or demands arising out of such injuries or losses. I understand that this release includes any claims based on negligence, action or inaction of the YMCA of Topeka, its staff, directors, members and guests.

______________________________ ______________ ______________________________ ______________

Print Name Relationship to child Sign Name Date

____ ______________________________

If the health history form was completed by a person other than a Parent/Guardian Who provided you with this information? What is that person's relationship to the child?

Child and Adult Care Food Program
ENROLLMENT/INCOME ELIGIBILITY FORM

PART 1 – CHILDREN'S INFORMATION—Required for all children in care.

Child's Name	Birthdate	Age	Circle Normal Days/ Print Normal Hours of Care	Circle Meals and Snacks Normally Received
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack

INCOME ELIGIBILITY

Please check the boxes that apply to help determine the other parts of this form to complete:

☐ A family member in our household receives benefits from Food Assistance (FA), Temporary Assistance for Families (TAF), or Food Distribution Program on Indian Reservations (FDPIR). (Please complete Part 2 and 5.)

☐ One or more of the children in Part 1 is a foster child. (Please complete Part 3 and 5.)

☐ My child(ren) may qualify for Free/Reduced Price meals based on household income. (Please complete Part 4 and 5.)

☐ My child(ren) will not qualify for Free/Reduced Price meals. (Please complete Part 5 only.)

PART 2 – HOUSEHOLD MEMBER RECEIVING FA/TAF/FDPIR— Any household member receiving benefits can establish eligibility for all children in the household.	Case Number or Identification Number

PART 3 – FOSTER CHILDREN—List the names of any children listed in Part 1 who are foster children.

PART 4 – TOTAL HOUSEHOLD GROSS INCOME FROM LAST MONTH—Not required if you have reported a case number in Part 2.

Tell us how much and how often. If no income, write "0". Use net income if self-employed.

List names (First and Last) of everyone in your household, including foster children	Earnings from Work Before Deductions	Weekly	Every 2 Weeks	2X Month	Monthly	Welfare, Alimony, Child Support	Weekly	Every 2 Weeks	2X Month	Monthly	Retirement, Pensions, Social Security, Other	Weekly	Every 2 Weeks	2X Month	Monthly
1.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
2.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
3.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
4.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
5.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
6.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

PART 5 – SIGNATURE AND CERTIFICATION—REQUIRED

The adult household member who fills out the application must sign below. If Part 4 is completed, the adult signing the form must also list the last four digits of his/her Social Security Number (SSN) or check the box if no SSN. *See Privacy Act Statement on the back of this page.*

If you have listed a case number in Part 2 or are applying on behalf of a foster child, or have checked the box that your child(ren) will not qualify for Free/Reduced Price meals, the last four digits of the SSN is not needed.

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Signature of Adult	Today's Date	Print Name of Adult Signing
X____________________________	____________	Social Security Number (SSN) (last four digits) XXX-XX- ☐ Check if no SSN
Address	City/State/Zip Code	Daytime Phone

PART 6 – CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Pacific Islander ☐ White

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, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Food Assistance (FA), Temporary Assistance for Families (TAF) or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child 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 the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

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 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, 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:

MAIL*: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue SW
Washington, D.C. 20250-9410

FAX: 202-690-7442
EMAIL: program.intake@usda.gov

***Only use this address if you are filing a complaint of discrimination.**

This institution is an equal opportunity provider.

DO NOT FILL OUT - CENTER USE ONLY

☐ Child(ren) are categorically free based on FA/TAF/FDPIR.

☐ Homeless, migrant, runaway or head start documentation from school, emergency shelter or agency.

☐ Foster child(ren) have been identified on this form and qualify for the free category.

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

☐ Child(ren) on this form who are not categorically eligible qualify as follows:
Check one: ☐ Free
☐ Reduced Price
☐ Paid

Household Size: ____________

Total Income: $____________
☐ Annual ☐ Monthly ☐ Twice Per Month
☐ Every Two Weeks ☐ Weekly

X____________________________
Signature of Determining Official

____
Today's Date

X____________________________
Signature of Confirming Official

____
Today's Date

NOT VALID WITHOUT SIGNATURE AND DATE.
E/IEF Effective Date: If the institution is using the parent/guardian signature date as the effective date, the form must have been signed by the institution representative within the same month the parent signed the form or the immediately following month. If the institution representative does not evaluate and sign the E/IEF within these guidelines, the institution representative's signature date must be used as the effective date.

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

PrimeTime
Lowman Hill
Stout
Berryton
SHHS

Letter of Cancellation or Termination

Effective ________________(Date)__I would like to cancel the following week or weeks of Prime Time. Thanks for your prompt attention to this matter.

Child's Name:____________________________
School:__________________________________
Week/Weeks:___________________________

Pursuant to the agreement between the YMCA and ______________________,
(Parent/Guardian)
either party may cancel or terminate the contract with a two weeks' notice.

Date:______________________________

Parent Signature:____

YMCA of Topeka
ymcatopeka.org
(785) 271-7979