Hosanna House, Inc.
After School Program 4-13 years' old
Application

Child Name: _____ **Birth Date:** _____

Start Date: _____

Parent/ Guardian Name: _____

Current Address: _____

_____

Phone Number: **Home:** _____ **Cell:** _____

Work: _____

Days of Care: Monday Tuesday Wednesday Thursday Friday

Hours of Care: _____ to _____

School Child will be Attending: _____

School Phone Number: _____

Grade: _____

Subsidy Information:

☐ **CCIS** ☐ **Full Pay** ☐ **CYF**

Comments/Notes: _____

_____

_____

_____

_____

Parent Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

Hosanna House INC
Child Development Center

FEE AGREEMENT

Childs Name _____ Date of Birth _____

Parent's Name _____ Start Date _____

Phone Number _____ Cell Phone Provider _____

People who child can be release to Class Room _____

_____

_____

Services Provided by HHI include Breakfast, Lunch, Snack, Quality Programming, and transportation fro school age children.

Hours (Please note the hours that your child will be in attendance An extra $25 00 will be assessed to any additional time)

Days of Care Monday Tuesday Wednesday Thursday Friday

Hours of Care _____ to _____

Rates
$20 00 Non-Refundable Application Fee

Toddler 1	$210.50 Per Week
Toddler 2&3	$198.00 Per Week
Pre-School	$190.50 Per Week
After-School	$136.00 Per Week
Pre-K	$0 ($25.00 per day for any child picked up after 3 10 pm or dropped off before 8:00 am)
Wrap Around	$88.25 Per Week
Kindergarten	$196.00 Per Week

Payments are due one week in advance on Friday Children will not be accepted in accounts more than 2 weeks' delinquent

Please select on of the following
☐ CCIS Subsidized Weekly Co-Pay _____
(Please note we will not accept children if co-pay is more than 2 weeks delinquent)

☐ CYF ☐ Full Pay ☐ HUD

Late Fees Verbal Warning
$25 00 per child after 6 10 pm (1st offense)
$50.00 per child after 6:10 pm (2nd offense)
$75 00 per child (3rd offense)
Termination (4th offense)

Parent Signature/ Date: _____ HHI Signature/ Date: _____

The above information has been explained to me and I agree to the terms and conditions set by CCIS and Hosanna House Inc I understand that if I should louse my subsidy for any reason I will be billed at the full daycare tuition rate for the period that I am unsubsidized I also understand that my weekly tuition is due every Friday in advance and if I become more than two weeks delinquent I will be terminated from the center

I have received a HHH CDC handbook and understand all terms and conditions

I agree to update the emergency contact and fee agreement whenever changes occur or every 6 months at minimum

HHI Signature _____

Parent Signature _____

Periodic Review _____

EMERGENCY CONTACT PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270 124(a)(b), 3270 181 & 182, 3280 124(a)(b), 3280 181 & 182, 3290 124(a)(b), 3290 181 & 182

CHILD'S NAME | BIRTH DATE

ADDRESS

MOTHER'S NAME/LEGAL GUARDIAN | HOME TELEPHONE NUMBER

E-MAIL ADDRESS | MOBILE TELEPHONE NUMBER

ADDRESS

BUSINESS NAME | BUSINESS TELEPHONE NUMBER

ADDRESS

FATHER'S NAME/LEGAL GUARDIAN | HOME TELEPHONE NUMBER

E-MAIL ADDRESS | MOBILE TELEPHONE NUMBER

ADDRESS

BUSINESS NAME | BUSINESS TELEPHONE NUMBER

ADDRESS

EMERGENCY CONTACT PERSON(S) | NAME | TELEPHONE NUMBER WHEN CHILD IS IN CARE

PERSON(S) TO WHOM CHILD MAY BE RELEASED | NAME | ADDRESS | TELEPHONE NUMBER WHEN CHILD IS IN CARE

NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER | TELEPHONE NUMBER

ADDRESS

SPECIAL DISABILITIES (IF ANY) | ALLERGIES (INCLUDING MEDICATION REACTIONS)

MEDICAL OR DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION | MEDICATION SPECIAL CONDITIONS

ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD

HEALTH INSURANCE COVERAGE FOR CHILD OR MEDICAL ASSISTANCE BENEFITS | POLICY NUMBER (REQUIRED)

PARENTS SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT

OBTAINING EMERGENCY MEDICAL CARE | ADMIN. OF MINOR FIRST - AID PROCEDURES

WALKS AND TRIPS | SWIMMING

TRANSPORTATION BY THE FACILITY | WADING

PERIODIC REVIEW

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part

CHILD'S NAME (LAST)	(FIRST)	PARENT/GUARDIAN
DATE OF BIRTH	HOME PHONE	ADDRESS
CHILD CARE FACILITY NAME		
FACILITY PHONE	COUNTY	WORK PHONE

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child

PARENT'S SIGNATURE

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY)
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY)
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER ADDRESS		SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT TITLE
	PHONE	LICENSE NUMBER DATE FORM SIGNED

Parents may write immunization dates; health professional should verify and complete all data.

Hosanna House Inc.
Guidance and Discipline Policy

Our philosophy for Hosanna House is for each child to be nurtured in a non-threatening environment, which does not incorporate the use of corporal punishment Staff shall help ensure children develop self-control and assume responsibility for their own actions Limits and consequences shall be clear and understandable to children, consistently enforced and explained to the child before and as part of any disciplinary action Firm positive statements about behaviors or redirection of behaviors shall be our goal In circumstances where a child may need to be removed from the group to help a child gain control it shall not exceed one minute per year of age Children shall not be disciplined for toilet accidents Corporal punishment, including hitting, spanking, swatting, beating, shaking, pinching and other measures intended to induce physical pain or fear, any threatening or actual withdrawal of food, rest or use of the bathroom, abusive or profane language, public or private humiliation, including threats of physical punishment or any form of emotional abuse, including shaming, rejecting, terrorizing or isolating a child is not acceptable or tolerable

Children shall have reasonable opportunity to resolve their own conflicts Discipline shall be the responsibility of adults who have an ongoing relationship with the child In certain circumstances, where the center has been unsuccessful in resolving the child's behavior, we will request assistance of the child's parent(s) Any program developed with the assistance of the parent will include the Director, Staff and Parent(s) monitoring the progress of this plan of action

When children are in an out-of-control rage, staff may gently but firmly hold them to prevent them from harming themselves or others They may use just enough force to restrain them safely Staff will always speak in a reassuring, calm voice and release them as soon as the aggressive behavior ceases All staff will obtain professional development during in-service on how to properly restrain children

When all efforts by the center and parents have been unsuccessful the center reserves the right to begin the process of terminating services for the child All efforts will be documented in the child's file, along with appropriate consents All staff working with the child shall receive training on implementing the plan

Discharge Policy

Unfortunately, at times, despite the best efforts of our staff, any child who, after attempts have been made to meet the child's individual needs, demonstrates inability to benefit from the type of care offered by our program, or whose presence is detrimental to the group shall be discharged from the program

In all instances, when Hosanna House decides that it is in the best interest for the child to terminate enrollment, the child's and parents' needs shall be considered by planning with the parents to meet the needs when they leave the facility We will make referrals to other agencies or programs to the best of our ability

Child's Name _____

Parent or Guardian _____

Date _____

Hosanna House CDC Authorization to Photograph

I give my permission for my child _____ to be photographed by Hosanna House staff or affiliates. I understand that photographs may be used for publicity for Hosanna House funding purposes, state wide reports which may be used on the internet and other publications that refer to our center.

Signature of Parent or Guardian _____

Date _____

___ DO NOT give my permission for my child to be photographed

Child and Adult Care Food Program — Sponsor: _____

Child Enrollment Form (Sample)

Center: _____

ENROLLMENT FORM FOR CHILDREN IN CHILD CARE (SAMPLE)

This document does not have to be completed for children in Emergency Shelters, Outside School Hours, and/or At-Risk programs. It is recommended to have new CACFP Annual Enrollment Forms completed each year during the Household Eligibility Application renewal period. Review completed enrollment form and enter the effective date in lower right hand section

PARENTS: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents and guardians to complete a CACFP Annual Enrollment Form when enrolling their child(ren) and again every year thereafter. This information will help ensure all children receive appropriate meals during their care

Please complete all areas to include signing and dating same.

FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FIRST CHILD	☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ BREAKFAST ☐ A M SNACK ☐ LUNCH ☐ P M SNACK ☐ SUPPER ☐ EVENING SNACK
NAME		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
BIRTH DATE		Other								
AGE		Enrollment Date:			Withdrawal Date:					
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	**DAYS OF WEEK IN ATTENDANCE**	**TIMES CHILD NORMALLY ATTENDS DURING WEEK**								**MEALS RECEIVED**
		TIME-IN			**TIME OUT**			**TIME CHILD ATTENDS SCHOOL**		
		☐ *Same Times as Above*								
		AM	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
SECOND CHILD	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A M SNACK ☐ LUNCH ☐ P M SNACK ☐ SUPPER ☐ EVENING SNACK
NAME		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
BIRTH DATE		Other								
AGE		**Enrollment Date:**			**Withdrawal Date:**					
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	**DAYS OF WEEK IN ATTENDANCE**	**TIMES CHILD NORMALLY ATTENDS DURING WEEK**								**MEALS RECEIVED**
		TIME-IN			**TIME OUT**			**TIME CHILD ATTENDS SCHOOL**		
		☐ *Same Times as Above*								
		AM	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
THIRD CHILD	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A M SNACK ☐ LUNCH ☐ P M SNACK ☐ SUPPER ☐ EVENING SNACK
NAME		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
BIRTH DATE		Other								
AGE		**Enrollment Date:**			**Withdrawal Date:**					
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	**DAYS OF WEEK IN ATTENDANCE**	**TIMES CHILD NORMALLY ATTENDS DURING WEEK**								**MEALS RECEIVED**
		TIME-IN			**TIME OUT**			**TIME CHILD ATTENDS SCHOOL**		
		☐ *Same Times as Above*								
		AM	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
FOURTH CHILD	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A M SNACK ☐ LUNCH ☐ P M SNACK ☐ SUPPER ☐ EVENING SNACK
NAME		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
BIRTH DATE		Other								
AGE		**Enrollment Date:**			**Withdrawal Date:**					
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	**DAYS OF WEEK IN ATTENDANCE**	**TIMES CHILD NORMALLY ATTENDS DURING WEEK**								**MEALS RECEIVED**
		TIME-IN			**TIME OUT**			**TIME CHILD ATTENDS SCHOOL**		
		☐ *Same Times as Above*								
		AM	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
FIFTH CHILD	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A M SNACK ☐ LUNCH ☐ P M SNACK ☐ SUPPER ☐ EVENING SNACK
NAME		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
BIRTH DATE		Other								
AGE		**Enrollment Date:**			**Withdrawal Date:**					

Signature _____

Signature of Parent or Guardian _____ *Date* _____ *Telephone Number of Parent or Guardian*

CHILD CARE REPRESENTATIVE USE ONLY

_____ _____

Name of Representative/Signature *Date*

The effective date can be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month this form is received

Child and Adult Care Food Program
Child Care Center Meal Benefit Income Eligibility Form

Part 1. All Household Members

Names of Enrolled Child(ren) (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
	☐	☐
	☐	☐
	☐	☐

Names of all Household Members (First, Middle Initial, Last)

	☐	☐
	☐	☐
	☐	☐
	☐	☐

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

NAME:_____ CASE NUMBER: ___ ___ - ___ ___ ___ ___ ___ ___ ___

Part 3. If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call **[Your cente director, Homeless Liaison, Migrant Coordinator 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 Incom
(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 3 is completed, the adult signing the form must also list the la 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 hom 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: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____

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

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

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 (Paid)_____ Date Withdrawn: _____

Reason for Denied: _____

Temporary: Free_____ Reduced_____ Time Period: _____(expires after _____ days)

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up 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.

Household size	Yearly
1	$22,459
2	$30,451
3	$38,443
4	$46,435
5	$54,427
6	$62,419
7	$70,411
8	$78,403
Each additional person:	+$7,992

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.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."