girls inc.

Inspiring all girls to be strong, smart, and bold

Girls Inc. of New Hampshire
2019/2020 After School Program Application

OFFICE USE ONLY
Weekly Fee _____
CACFP: _____
Center: _____

DATE OF ENROLLMENT:_____ SCHOOL ATTENDING _____ GRADE_____

_____ / / _____
LAST NAME FIRST NAME DOB AGE

_____
STREET CITY/TOWN STATE ZIP HOME #

_____ _____
MOTHER'S/GUARDIAN NAME FATHER'S/GUARDIAN NAME

_____ _____
EMPLOYER EMPLOYER

_____ _____
HOME ADDRESS HOME ADDRESS

_____ _____
WORK # CELL # WORK # CELL #

Consents

I authorize **Girls Inc. of New Hampshire** to contact the following person(s) who will assume responsibility for my child in the event I can not be reached immediately in an emergency:

Name: _____ Phone: _____

Name: _____ Phone: _____

I authorize **Girls Inc.** to release my child to the following individuals other than parent or guardian:

Name: _____ Phone: _____

Name: _____ Phone: _____

I authorize Girls Inc. staff to administer basic and temporary first aid to my child if necessary. In the event of a serious injury I give Girls Inc. permission to transport my child to a hospital or other emergency facility to receive emergency medical treatment. I also authorize ambulance/rescue squad attendants to administer such treatment as is medically necessary and I authorize licensed health practitioners working in the hospital or emergency medical facility to examine and provide emergency medical treatment to my child if warranted. I understand that I will be contacted by Girls Inc. personnel as soon as possible regarding any emergency involving my child.

Yes ☐ No ☐

I give my child permission to attend local outings as part of the daily activities of Girls Inc. program. (Park, playground, library, etc.)

Yes ☐ No ☐

I authorize Girls Inc. to publish my child's name and photograph in the newspaper, Girls Inc. social media outlets, newsletter, web page or other promotional publications/video.

Yes ☐ No ☐

_____ _____
PARENT SIGNATURE DATE

Medical Information
Any chronic conditions, allergies or medications that could be important in case of sudden illness or injury:

_____

Child's Physician: _____Phone:_____

Registration Information

Registration may be made in person or by mail for Girls Inc. A non-refundable $25.00 registration fee and completed payment authorization form, including a copy of a credit card or voided check is required for participation.

Financial Assistance
Financial assistance is available to families who qualify. Eligibility is based on financial need and will require proof of income including employer paystubs, child support verification, etc. and completion of a Financial Aid Form. Girls Inc. will notify parents if/when they are approved for assistance. Those who may qualify for NH State Child Care Assistance will be required to complete Form 1863.

Late pick-up fees
Any families with late pick-ups will be charged $5.00 for the first 5 minutes, per child and then $1 a minute thereafter. Excessive late arrivals may result in termination from the program. This fee is required at the time of pick up.

Returned Check Fee
Girls Inc. policy states that there is a $10 returned check/EFT fee. This fee will be automatically charged to your account plus the amount of the returned check/EFT.

Health Forms
The State of New Hampshire requires that all members have a completed health form on file at the center prior to attending the program. This form requires all immunization dates and a physical exam with a physician's signature within two years prior to attending camp. A copy of the school health form including immunizations, if current, is acceptable.

Licensing statement
The licensing authority for this program is the Bureau of Licensing and Certification, Child Care Licensing unit. Child care programs are required to post a copy of the statement of findings and corrective action plan for the most recent visit in a location which is accessible to parents and must maintain copies of the statement of findings and corrective action plan for the preceding visit and make them available for parents to review upon request. Statements of findings and corrective action plans are also available online at https://nhlicenses.nh.gov/verification/search or by calling the bureau at 603-271-9025 or 1-800-852- 3345, extension 9025. During visits to programs, licensing staff speak with children regarding the care they receive at a program if in the judgement of the licensing staff the children's response would be valuable in determining compliance with licensing rules. Licensing staff are experienced in working with children and trained to speak with children in a manner that is respectful and non-leading. Children will remain with their class or group during conversations with licensing staff and at no time will a child be forced to speak with a licensing coordinator. If licensing staff believes your child may have specific information regarding an alleged event at the program and determines it is best to interview your child separately and not with their class or group, please indicate your preference among the following options:

☐ I give permission for child care licensing staff to interview my child at the child care program separate from his or her class or group.

☐ I wish to be notified prior to child care licensing staff interviewing my child at the child care program separate from his or her class or group.

☐ I do not give permission for child care licensing staff to interview my child at the child care program separate from his or her class or group.

I have read and fully understand the above polices.

_____ _____

Parent/Guardian signature Date

Demographic Information

Girls Incorporated of New Hampshire would like to thank you for assisting us with the collection of the following information. We respect your privacy and have included no identifying information. This information is solely for collection and analysis, as a tool to help us better understand the diversity of our community.

What is your child's racial background?

Asian American or Pacific Islander	
Black or African American	
Hispanic or Latina	
Native American or American Indian	
White, European American or Anglo	
Multiracial/Mixed Heritage	
Other	

What language(s) is most often spoken at home?

English	
Spanish	
French	
Other _____	
Other _____	
Other _____	

Who lives with the child at home?

Two parents	
Mother only	
Father only	
One parent at a time (Joint Custody)	
Neither parent (e.g. Foster home, grandparent)	
Parent in Military	

What is your family income?

Less than $10,000	
$10,000-$15,000	
$15,000-$20,000	
$20,000-$25,000	
$30,000-$50,000	
Greater than $50,000	
Other	

☐ Section 8
☐ Public Housing

Confidential
Scholarship/Financial Aid Application

Head of Household

LAST NAME FIRST NAME Telephone #

STREET ADDRESS

CITY STATE ZIP

Relationship to child(ren) _____

LIST ALL MEMBERS OF YOUR HOUSEHOLD	DATE OF BIRTH	CURRENTLY WORKING? YES OR NO	TOTAL GROSS MONTHLY INCOME (INCLUDING CHILD SUPPORT)

Are you currently in a training or school program? ☐ If YES, where? _____

I certify, under penalty of perjury, that the above information is correct and complete to the best of my knowledge. I will immediately report to Girls Incorporated of New Hampshire any change in income or family size.

_____ _____

Parent/Guardian Signature DATE

_____ _____

Staff Signature DATE

Payment Authorization Form

2019/2020 After School Program Center_____

Child's Name:_____

Start Date: _____**Amount per Cycle** (BIWEEKLY): _____

Billing Cycle: BIWEEKLY on Tuesdays for as long as the child is enrolled.

I hereby authorize Girls Inc. of New Hampshire to initiate credit entries and if necessary, to initiate any debit entries to correct erroneous credit entries to my (our) account indicated below and the financial institution indicated below. This authority is to remain in full force and effect until Girls Inc of New Hampshire has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Girls Inc. of New Hampshire and depository a reasonable opportunity to act on it. **A $10 fee will be charged each time to accounts whose weekly fee is declined/returned.**

Parent/Guardian/ Card holder Last Name _____

First Name _____Middle Initial_____

Address _____

City, State & Zip _____

Phone number _____

CHECK ONE: ☐ Mastercard ☐ Visa ☐ Checking ☐ Savings

Card Number _____

Expiration Date _____ 3- digit Security Code _____

OR complete the info below for checking/savings account withdrawal. A voided check must be attached.

Bank Name _____

Routing Number: _____Account # _____

CHECK ONE: ☐Checking ☐Savings

Payments will be deducted automatically biweekly on Tuesdays (early morning). Funds must be in the listed account by the close of business on Monday. In the event the payment is declined, another payment will be charged the NEXT day with the additional $10 fee. A second decline requires immediate action to continue in our program. PLEASE INITIAL _____

I fully understand the above information

_____

Parent/Guardian/Card holder signature: Date

2019/2020 Payment Dates

After school payments will be deducted **BIWEEKLY** on the following dates (Tuesdays). Funds must be available on these dates to avoid fees for insufficient funds.

8/27/19 (Manchester will only be charged for one week as school starts on 9/4/19)
9/10/19
9/24/19
10/8/19
10/22/19
11/5/19
11/19/19
12/3/19
12/17/19
1/14/20
1/28/20
2/25/20
3/10/20
3/24/20
4/7/20
4/21/20
5/5/20
5/19/20
5/21/19
6/2/20

IMPORTANT: Fees will remain the same the ENTIRE school year. The only exceptions are listed above in the schedule.

We do not increase our fees for teacher workshop days, half days, and February and April school vacation weeks. We will not reduce fees due to holidays, illness, snow days, and family vacations. Fees will be charged to the account on file unless written notice of termination is submitted to the Director two weeks in advance.

I have read and fully understand the above policies.

_____

Parent/Guardian Signature **Date**

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (CHILD CARE/FDCH)

PART 1. ALL HOUSEHOLD MEMBERS

Names of all household members (First, Middle Initial, Last)	Name of each child's school /or indicate "NA" if child is not in school	Place a check in the box below if child is a foster, homeless, migrant, runaway, or Head Start child. If each child attending school is a foster, homeless, runaway, migrant or in Head Start, skip to part 4 to sign this form.					Place a check in the box if NO income
		Foster	Homeless	Migrant	Runaway	Head Start	

PART 2. BENEFITS: If any member of your household receives SNAP or TANF ASSISTANCE, provide the name and case number for the person who receives benefits and skip to part 4. if no one receives these benefits, skip to part 3.

NAME:_____ PROGRAM NAME _____ CASE NUMBER:*(NOT EBT CARD#)* _____

PART 3. TOTAL HOUSEHOLD GROSS INCOME (BEFORE DEDUCTIONS). List all income on the same line as the person who receives it. Check the box for how often it is received. RECORD EACH INCOME ONLY ONCE.

1. Name (list **only** household members with income)	2. GROSS INCOME AND HOW OFTEN IT WAS RECEIVED																			
	Earnings from work before deductions	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Welfare, child support, alimony	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Social Security, SSI, VA, retirement benefits	Weekly	Every 2 Weeks	Twice Monthly	Monthly	All other income (such as Unem-ployment) benefits	Weekly	Every 2 Weeks	Twice Monthly	Monthly
(Example) Jane Smith	$200	X				$150		X			$0					$0				
	$					$					$					$				
	$					$					$					$				
	$					$					$					$				
	$					$					$					$				
	$					$					$					$				
	$					$					$					$				

PART 4. SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (ADULT MUST SIGN): An adult household member must sign the application. **If Part 3 is completed, the adult signing the form also must list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Statement on the back of this page.)

I certify (promise) that all information on this application is true and that all income is reported. I understand that the school will get Federal funds based on the information I give. I understand that school officials may verify (check) the information. I understand that if I purposely give false information, my children may lose 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 5. CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)			
Choose one ethnicity:	*Choose one or more (regardless of ethnicity):*		
❑ Hispanic/Latino	❑ Asian	❑ American Indian or Alaska Native	❑ Black or African American
❑ Not Hispanic/Latino	❑ White	❑ Native Hawaiian or other Pacific Islander	

Your children may qualify for free or reduced price meals if your household income falls at or below the limits on this chart.

FEDERAL ELIGIBILITY INCOME CHART For School Year **2015-2016**

Household size	Yearly	Monthly	Weekly
1	$ 21,775.00	$ 1,815.00	$ 419.00
2	29,471.00	2,456.00	567.00
3	37,167.00	3,098.00	715.00
4	44,863.00	3,739.00	863.00

Household size	Yearly	Monthly	Weekly
5	52,559.00	4,380.00	1,011.00
6	60,255.00	5,022.00	1,159.00
7	67,951.00	5,663.00	1,307.00
8	75,647.00	6,304.00	1,455.00
Each additional person	$ 7,696.00	$ 642.00	$ 148.00

DO NOT FILL OUT THIS PART. THIS IS FOR SCHOOL 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____ Date Withdrawn: _____

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Verifying Official's Signature: _____ Date: _____

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 your child 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 last four digits of 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 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 if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. 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. The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the basis of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202)690-7442 or email at program.intake@usda.gov.
Individuals who are deaf, hard of hearing 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.**