FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

CENTRAL CONNECTICUT COAST YMCA

Infant, Toddler, Preschool and School-Aged Child Care

Summer Camp 2026

Child's Name ______________________________ D.O.B ______________

Group Name ______________________________ Start Date ______________

Checklist Documentation

- o Emergency Form
- o Registration & Release Form
- o Payment & Session Registration Form
- o Payment Authorization
- o Information Sheet
- o Waivers & Acknowledgements
- o Photo/Liability Waiver
- o Transportation/Swim Permission Form
- o Behavior Contract
- o Behavior Management Plan
- o Authorization for Access/Release of Information
- o Child's Assessment/Medical Evaluation/Immunization
- o Medication Authorization Form (If needed)
  Brand new medication unopened with RX information label
  Action Plan/Care Plan
  - IEP (Individual Education Plan) for Preschool and SACC or IFSP (Individual Family Service Plan) for Infant/Toddler
- o Copy of Parent ID
- o Proof of Address
- o Birth Certificate
- o Copy of Child Medical Card
- o Care 4 Kids Application (Provide all documents that are needed: proof of income 2 consecutive paystubs if you get paid bi-weekly and 4 consecutive paystubs if you get paid weekly. If you are paid by cash, you must provide a letter how much you get paid and state whether if it's bi-weekly or weekly must be notarized and have the person information you work for on the letter.)
- o Parent Fee Determination/ Financial Assistance Form

OFFICE STAFF ONLY

Please list missing documentation or note:

____

____

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Central Connecticut Coast YMCA

Infant, Toddler, Preschool, SACC Information Sheet

Child Information

Child's Name: ______________________ D.O.B ______________________

Address: ____

Best Contact Phone: __________________ Email: ______________________

Medical Information

Diagnosed with Asthma: ◯YES ◯NO Inhaler needed at School: ◯YES ◯NO

Individual Care Plan on File: ◯YES ◯NO

Diagnosed Allergies: ____

____

____

____

Other Medical Information: ____

____

____

____

Emergency Contact/ Pick-up Information. Must be 18 and Older.

Name of Person	Relationship to Child	Contact Number	D.O.B
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Parent/ Guardian Signature:______________________________ Date: ____________

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CENTRAL CONNECTICUT COAST YMCA
Infant, Toddler, Preschool and SACC Summer Camp 2026
Registration & Release Forms

Member ID# ________________

Camper's First Name ______________________ Last ______________________ Gender________

Address ______________________ City ______________________ State ____ Zip __________

Date of Birth ______ Age entering camp yrs ___ mos ___ Grade entering in Sept ______ Child lives with ______________

Office Use - Program Name ______________________ Start Date ______________________

Parent # 1 ______________________ Parent #2 ______________________

Relationship to Child ______________________ Relationship to Child ______________________

Home address ______________________ Home address ______________________

City/State/Zip ______________________ City/State/Zip ______________________

Place of Employment ______________________ Place of Employment ______________________

Employment address ______________________ Employment address ______________________

City/State/Zip ______________________ City/State/Zip ______________________

Info will be sent via Email:
Email ______________________ Email ______________________

Please check which phone number you would like used as Primary Contact number:

☐Home Phone # (   )______________________ ☐Home Phone # (   )______________________

☐Cell Phone # (   )______________________ ☐Cell Phone # (   )______________________

☐Work Phone # (   )______________________ ☐Work Phone # (   )______________________

The YMCA is required to permit either parent to pick up the child unless the YMCA is furnished with a court order to the contrary. Please list below any persons not authorized to pick up this child and attach the original copy of the court order.

Name______________________________________ Relationship ______________________

If parent cannot be reached, give name and relationship of person to be called in case of an emergency. Must be 18 & Older.

Name ______________________________________ Relationship ______________________

Home # (   ) __________________ Work # (   ) __________________ Cell # (   ) __________________

Parent/ Legal Guardian Permission:

I understand that the Central Connecticut Coast Young Men's Christian Association, Inc. (the "Parent Company") and all of its branches are a charitable organization that makes its programs and facilities available to persons only on the condition that they agree to assume full responsibility for injury and damage. Therefore in exchange for acceptance of the child in the YMCA programs, I release, on behalf of the child, myself and members of the child's family, the YMCA, the Parent Company, and officers, directors, employees and volunteers from all claims of damage or loss to the child's property and claims of personal injury or property damage caused to others by the child, including injury or damage to YMCA property or personnel.

I understand the financial requirements, registration, payment obligations and deadlines as outlined in the Preschool Handbook. By signing this document, I affirm that I am the person legally responsible by law to make decisions for the well-being of the above named child.

Signature of Parent/Guardian ______________________________________ Date ______________

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CENTRAL CONNECTICUT COAST YMCA
Infant, Toddler, Preschool and SACC Summer Camp 2026
Payment & Session Registration Form

Camper's First Name ______________________ Last ______________________ Gender ________

PAYMENT INFORMATION

A $50 non-refundable registration fee is required per camper.

A $50 non-refundable deposit is required to secure a session. ***(Deposits are non-transferrable and non-refundable)***

Session must be paid in full prior to the start of each session.
All families must apply for Care 4 Kids.
Credit card returns and returned check fees are $30.00.
Refunds may be issued for medical emergencies. (Physician notes will be required).
Failure to remit balance and signed medical form by due date will delay your child's enrollment.
The YMCA is a CACFP program participant. Breakfast, Lunch, and Snack will be provided.

(Refer to Day Camp Parent Handbook)

REGISTRATION INFORMATION
Check boxes (X) that you are interested in registering your child.

CIRCLE CAMPERS SHIRT SIZE*
Youth: S M L XL
Adult: S M L *size not guaranteed

Camp Hours 8:00 am-4:00 pm			Extended Camp 4:00-5:30 pm
☐ Week 1 June 22–June 26	Member $192	Program Participant $285	☐ Extended care $50/$75
☐ Week 2 June 29–July 3*	Member $154	Program Participant $228	☐ Extended care $50/$75
☐ Week 3 July 6–July 10	Member $192	Program Participant $285	☐ Extended care $50/$75
☐ Week 4 July 13–July 17	Member $192	Program Participant $285	☐ Extended care $50/$75
☐ Week 5 July 20–July 24	Member $192	Program Participant $285	☐ Extended care $50/$75
☐ Week 6 July 27–July 31	Member $192	Program Participant $285	☐ Extended care $50/$75
☐ Week 7 August 3–August 7	Member $192	Program Participant $285	☐ Extended care $50/$75
☐ Week 8 August 10–August 14	Member $192	Program Participant $285	☐ Extended care $50/$75
☐ Week 9 August 17–August 21	Member $192	Program Participant $285	☐ Extended care $50/$75

* Week 3 – Summer Day Camp will be closed on Friday, July 3 in observance of the 4th of July (the week will be pro-rated).

Registration Fee (per camper) $50
Total Weeks ____ x $50 Deposit per week = __________
Total Due at Registration = __________

Parent/Guardian Signature ______________________________ Date ______________
Staff Initial ____________ Date ____________

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CENTRAL CONNECTICUT COAST YMCA

Infant, Toddler, Preschool and SACC Summer Camp 2026

Payment Authorization

Camper's First Name ______________________________ Last ______________________________ Gender ________

Summer Camp Payment Agreement

I, ___________________________________, hereby authorize the Central Connecticut Coast YMCA to charge the account listed on the Monday, two weeks prior to the session start date to act as payment for Child Care services. I understand the final payment for each session is due no later than the Monday, two weeks before each session begins. If the session balance is not paid by that date, I am aware that my child will not be able to attend camp until the balance has been paid in full. I understand that I must provide THIRTY DAYS notice, in writing, if I wish to discontinue this service. These fees will be automatically drafted from my Child Care account. *To set up a different payment arrangement, please reach out to the Camp Director.

Camp Fees/ Refund Policy

Camp fees are due, in full, the Monday, two weeks prior to the session start date. Deposit fees and registration fees are non-refundable and non-transferable. Session refund requests must be done in writing on a Refund Request Form a minimum of 2 weeks prior, if I wish to discontinue this service. Refunds will not be granted less than 2 weeks before the start of a session. Refunds may be issued for medical emergencies. A physicians note will be required. There is a $10 administration fee for all refunds.

Service Fees/ Late Fees

A $25 late camp payment fee will be applied to accounts not paid in full by the Monday, two weeks prior to the session start date. There will be a $30 charge for any EFT or charge returned by the bank. A $30 fee for credit card returns and returned checks will be applied to outstanding balances. These fees will be automatically drafted from the account associated with Summer Camp payments. Failure to pay this fee will jeopardize your child's enrollment in camp.

Camp Payments

I authorize my bank to honor preauthorized Electronic Funds or credit card charges against my account for Summer Camp tuition payments as indicated below. When the bank honors the EFT or credit card by charging my account, such transfer shall constitute notice of payment due and my receipt for the payment. Should any preauthorized EFT or credit card not be honored by said bank when received by them, then it is understood that the payment is to be made by me in the amount of said payment plus service charge. It is further understood that if such payment is not honored by the bank or credit card institution, then the YMCA, at its discretion, may resubmit the amount due for payment on a future date.

☐ I choose to utilize the EFT option for payment from my __ Checking __Savings account.

*A Voided Check must be attached to this form.

Bank Name ______________________________ Name on Account ______________________________

Routing Number ______________________________ Account Number ______________________________

☐ I choose to utilize a credit card on file at the Y. Card Type ____________________ Last 4 digits ______________

☐ I choose to utilize the Credit Card Payment option for monthly payments (automatically charged to my card.).

Your credit card must be swiped at the YMCA Branch to save information.

Card Type: _American Express _Discover _MC _Visa

I understand that it is my responsibility to notify the YMCA of any change in address, bank account information (if utilizing bank draft for payment of Child Care) or credit card information/expiration date (if utilizing credit card for payment of Child Care).

I understand the financial requirements, payment obligations, refund policy, fees and deadlines as outlined.

Print Name ______________________________ Email ______________________________

Billing Address ______________________________ City ____________________ State _____ Zip ______________

Authorized Signature ______________________________ Date ______________________________

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CENTRAL CONNECTICUT COAST YMCA
Infant, Toddler, Preschool and SACC Summer Camp 2026
Information Sheet

Camper's First Name ______________________ Last ______________________ Gender ________

Authorized Pick Ups

Guardian Authorization: In order to ensure the well-being of all our participants and our ability to help you with picking up your child, please include every person that could assume the custody of your child for any unforeseen circumstances. The YMCA WILL require photo I.D. to release any child to an authorized pick-up person listed on this form. Individuals picking up your child must be 18 & Older. I authorize the YMCA to release my child to the custody of the following people other than me.

Name ____________________ Relationship __________ Phone __________ Phone __________
Name ____________________ Relationship __________ Phone __________ Phone __________
Name ____________________ Relationship __________ Phone __________ Phone __________

Special Social, Behavioral or Medical Needs

Does your child require an Individualized Education Plan? __Yes __No

Does your child require special accommodations (social,behavioral, medicine)? __Yes __No

If you chose Yes, please note the following:

- An Individual Care Plan (ICP), completed by parent/guardian, is required by May 1st.
- Authorization of Medication Forms and Care Plan provided by Physician, signed by a Physician and parent/ guardian are due by May 1st.
- We want to provide a positive and successful experience for all children. If your child has social, behavioral or developmental needs, please contact the Camp Director by May 1st to discuss their needs and required support.

Getting to know your Child:
The YMCA believes that every child in our care is a unique individual with special needs. Help us to provide the best care for your child by providing us with any information about your child that you think would benefit the staff from knowing to help ensure a successful/safe time at camp. We strongly encourage you to meet with the Director and visit the program prior to enrolling your child. ____

____

____

____

Signature of Parent/Guardian ______________________________________ Date __________

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CENTRAL CONNECTICUT COAST YMCA
Infant, Toddler, Preschool and SACC Summer Camp 2026
Waivers & Acknowledgements

Camper's First Name ____________________ Last ____________________ Gender ______

Parent/Guardian Permission

- I acknowledge that I have received a copy of the YMCA Child Care Parent Handbook which covers the following information: general policies, accounting policies, days program is closed and complaint procedure. I understand that if I have any questions in regard to the content of this handbook it is my responsibility to notify the YMCA at the earliest convenience. Initial ___
- I agree to arrange for my child to be picked up from the program if they become ill and to keep the child home until their condition is considered safe and appropriate for participation. Initial ___
- I hereby give permission for my child to participate in all activities, including field trips, that are part of the camp program. I understand that there are risks associated with camp activities and programs in which my child is a participant. I hold the Y Branch, the Central Connecticut Coast YMCA, its employees, representatives, agents and assigns from any and all claims whatsoever against said parties resulting from or caused by my child's participation. Initial ___
- I hereby give my consent for my child to participate in activities that involve water and recreational swimming while under the supervision of the YMCA staff or their representatives where it applies. Initial ___
- I hereby give my consent for my child to be transported by the YMCA staff or their representatives in a YMCA Vehicle or contracted Bus Transportation. I hereby give permission for my child to be transported by the YMCA for emergency situations when the camp needs to be evacuated for the safety of the children. Initial ___
- I grant permission to have my child transported to one of the YMCA's other facilities in case of inclement weather. Initial ___
- I grant permission for any pictures taken of my child while at camp to be used for publicity and promotional purposes. Initial ___
- I understand that neither the YMCA nor any of its paid or volunteer workers can be held responsible in the events of an accident. I understand that all precautions will be taken to ensure the safety and health of my child. Initial ___
- I hereby give permission for the YMCA to apply sunscreen and/or bug spray to my child. I will supply sunscreen and/or bug spray for my child, as well as apply to my child prior to camp. The YMCA is NOT responsible for lost or stolen bottles of sunscreen/bug spray (please label containers). Initial ___
- I understand that the Site Location, the Y branch and the Central Connecticut Coast YMCA are not responsible for personal property lost, damaged, or stolen while members and/or program participants are using the facilities, on the premises, or involved in Y programs. Initial ___
- I understand that if I am receiving Care 4 Kids, my contract for child care and all associated fees is on file with the YMCA. If for any reason Care 4 Kids fails to pay, I, as a client of the YMCA, will be held responsible for the full child care tuition. By initialing, I agree with these terms. Initial ___
- I understand that my weekly payment is due every Friday for the upcoming week. If I am on a bi-weekly payment plan, I understand that my payment must be made every two weeks, in advance. I understand that a $30 fee will be applied for any returned payments (e.g., insufficient funds). Furthermore, I understand that if payment is not received by the due date, my child will not be allowed to attend the program until my balance is paid in full. Initial ___
- I understand that ALL updated Physical Forms, signed by a physician, must be turned into the camp office at the time of registration or the latest May 1st. Initial ___

Authorization for Medical Attention:

- I give permission for the YMCA Certified First-Aid staff to treat my child, if needed. I authorize the camp staff to consent to emergency treatment, under the advice of a Connecticut licensed physician, for my child when the need for such treatment is immediate and when efforts to contact me are unsuccessful. My child will be transported to the nearest emergency facility. I understand that any expense incurred, through transportation and the treatment of my child are my responsibility. Initial ___

Physicians Name ______________________________ Physicians Number (____) ______________
Hospital of Choice ____

Signature of Parent/Guardian ______________________________ Date ______________

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STAFF USE: Check the boxes below to indicate if the member has **DECLINED** to complete the following form.
☐ CCCY 2025 Photo Waiver

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CENTRAL CONNECTICUT COAST YMCA
Photo / Audio / Visual / Narrative Release Form
(For Adult Participants and Minor Participants with Parent/Guardian Consent)

☐ I am 18 years of age or older.
☐ I am under 18, and my parent or legal guardian has provided consent below.

Consent & License
By participating in activities or programs conducted by the Central Connecticut Coast YMCA, YMCA of the USA, or their chartered associations and collaborating partners ("The Y"), I grant permission — now and forever — for the creation, reproduction, editing, and use of:

☐ Photographs, Video recordings, Audio recordings, Written or spoken narratives about my experience

I provide The Y and its collaborating third parties with a **perpetual, worldwide license** to use these materials, in any format existing now or developed in the future, for purposes including:

☐ Promotion and advertising, Educational materials, Public displays or exhibitions, Commercial use

I understand:

☐ I may or may not be identified by name.
☐ My name will never be used to endorse specific products or services.
☐ I will not receive any payment or compensation for the use of these materials.
☐ I waive all rights to approve or review the final materials.

Ownership & Use
I further agree that:

☐ All materials created are the sole property of YMCA of the USA. The Y has no duty of confidentiality regarding these materials. The Y and its partners may use, adapt, and distribute these materials globally, indefinitely, without additional notice or payment to me.

Release of Liability
☐ I understand that my consent is final and cannot be revoked and I release and discharge The Y and its partners from any claims, demands, or legal actions arising from the use of these materials.

Participant Information
Please Check One:

☐ I am signing for myself as an adult participant.
☐ I am signing as the parent/legal guardian of a minor participant listed below.

Adult Participant Name (Print Clearly): ______________________________

Adult Participant Signature (if Over 18): ______________________________

Date: ____________________

If applicable – Minor's Name (Print Clearly): ______________________________
**For multiple children, list all their names on the lines*
____

Parent/Guardian Signature (if Minor Participant): ______________________________

Date: ____________________

CENTRAL CONNECTICUT COAST YMCA
Tim Bartlett, President & CEO
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STAFF USE: Check the boxes below to indicate if the member has **DECLINED** to complete the following form.

☐ CCCY 2025 Adult-Youth Liability Waiver

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CENTRAL CONNECTICUT COAST YMCA

General Participant Waiver, Release, Indemnification & Covenant Not to Sue

(For Adult Participants and Minor Participants with Parent/Guardian Consent) **PLEASE READ CAREFULLY. THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS AND IS LEGALLY BINDING. BY SIGNING THIS AGREEMENT, YOU ARE RELEASING CENTRAL CONNECTICUT COAST YMCA INC. FROM ALL LIABILITY AND FOREVER GIVING UP ANY CLAIMS THEREFORE.**

Assumption of Risk

I acknowledge and agree that any use of Central Connecticut Coast YMCA Inc. facilities, services, equipment, and premises ("Facilities") and any participation in Central Connecticut Coast YMCA Inc. programs and activities ("Programs") involves inherent risks, including but not limited to:

- ☐ Personal injury (moderate to severe)
- ☐ Property damage
- ☐ Disability
- ☐ Death
- ☐ Sickness or disease

I voluntarily accept and assume full responsibility for these and any other risks associated with the use of Facilities and participation in Programs. I confirm that I have full knowledge of the nature and extent of all such risks, whether or not they are fully described in this document.

Waiver, Release, Indemnification & Covenant Not to Sue

In consideration of the use of Facilities and participation in Programs, I, the undersigned:

- ☐ Agree that Central Connecticut Coast YMCA Inc., its officers, directors, agents, employees, volunteers, insurers, and representatives ("Releasees") shall not be liable for any injury, property damage, disability, death, sickness, or disease sustained by myself, my family members, dependents, guests, or Minor(s) listed below, regardless of cause, including negligence by Releasees.
- ☐ Accept full responsibility for any loss, damage, or injury arising from the use of Facilities and participation in Programs.
- ☐ Release, waive, and covenant not to sue Releasees for any cause of action, claims, suits, liabilities, or demands of any nature whatsoever, including negligence, related to use of Facilities or participation in Programs, whether supervised or unsupervised.
- ☐ Agree to indemnify and hold harmless Releasees from any and all claims, demands, losses, suits, liabilities, or costs, including attorney's fees, arising from or in any way related to use of Facilities and participation in Programs by myself, my family, dependents, guests, or Minor(s).

Participant Information

Please check one:

- ☐ I am participating as an **Adult Participant**
- ☐ I am the Parent/Guardian signing for a **Minor Participant**

If signing for a Minor Participant, I certify that I am the Minor's legal parent/guardian, have the authority to sign this agreement, and do so voluntarily on behalf of the Minor.

Adult Participant Name (Print Clearly): ______________________________

Adult Participant Signature (if Over 18): ______________________________

Date: ____________________

If applicable – Minor's Name (Print Clearly): ______________________________
**For multiple children, list all their names on the lines*

____

Parent/Guardian Signature (if Minor Participant): ______________________________

Date: ____________________

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CENTRAL CONNECTICUT COAST YMCA
Infant, Toddler, Preschool, & School Age Child Care
Transportation Permission Form

I herby give permission for my child ______________________________, for daily transportation to and from his/her school as indicated on my child's enrollment form as well as for emergency situations when the program needs to be evacuated for the safety of the children.

In the event of an emergency and I cannot be reached please call:

____At ____________________
(Emergency Contact Other than Parent/Guardian) (Phone Number)

I prefer my child to be taken to ______________________________hospital and in the event that my child requires emergency medical attention the following physician should be notified.

____
Physician's Name and number

____
Signature of Parent/ Guardian Date

Learn to Swim/Recreational Swim Permission Form

I, ____________________, the parent/guardian of ______________________________, give my permission for he or she to participate in the YMCA learn to swim and recreational swim program offered through After School Care, the Y Learning Center, Y Vacation Club, Y Fun Club, or Summer Day Camp. I release and agree to hold harmless the YMCA, its officers, directors, employees, or staff from any claim or damages that may occur as a result of my child's participation in the YMCA learn to swim and recreational swim program.

____
Signature of Parent/ Guardian Date

08/01/2025

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CENTRAL CONNECTICUT COAST YMCA
Infant, Toddler, Preschool and SACC Summer Camp 2026
Behavior Contract

Camper's First Name ______________________________ Last ______________________________ Gender _______

EXPECTATIONS

- Show respect by treating other children and adults the way I would want to be treated.
- Be honest, will always tell the truth about actions and feelings.
- Be a friend that others can trust.
- Demonstrate caring by helping others and treating them kindly.
- Take responsibility for my own behavior and accept the consequences for my actions.
- To be free from cruel teasing and insults.
- Have a safe, calm, clean and orderly environment.
- Make mistakes without being ridiculed by others.
- Seek help from those that are there to help. Talk with Camp Staff when frustrated or feel mistreated.
- Be treated with dignity and respect by everyone.
- Use appropriate, acceptable language. Don't talk back or use obscene, threatening language or speak in an unkind manner.
- Avoid fights or verbal abuse.
- Be fair and accepting of others eager to join any activity.
- Work and play safely.
- Be kind, considerate, helpful, and respectful towards others.
- Follow directions and listen attentively while participating in activities.
- Share equipment and materials fairly and use them properly.
- Respect property, especially things that do not belong to me.
- Cooperate with others who are there to help.
- Speak up when witnessing unfairness or offensive language or behaviors of others.
- Be a good sport whether I win or lose.
- Be truthful with everyone.

CONSEQUENCES

- Report of discipline for talking back, destroying property, bullying children, disrupting the program, refusing to obey. Parent will be required to sign these reports acknowledging that they have read the report. After three reports, child and parent may be required to meet with the Camp Leadership staff.
- Letter of discipline and immediately suspended for a minimum of one day for hitting, kicking, biting, spitting, scratching, swearing, making degrading or racial remarks, or leaving the group. Parents may be required to meet with the Camp Director before the child can return to the program.
- Camp services may also be terminated if the parent is physically or verbally abusive to a staff member. It is our desire that every child enjoys his/her experience in the program.
- Participation in the Summer Camp Program may be limited or discontinued if this contract is not followed.

Some behaviors may warrant our skipping procedure depending upon the severity of the inappropriate behavior.

______________________________ ______________________________
Parent/Guardian Signature **Child/Participant Signature**

____
Date

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CENTRAL CONNECTICUT COAST YMCA
Infant, Toddler, Preschool and SACC Summer Camp 2026
Behavior Management Plan

From time to time it may be necessary to discipline a child who continually exhibits a lack of respect or concern for the safety and well-being of their peers and/or staff.

Behavior management is used in the form of RE-DIRECTION or POSITIVE GUIDANCE and is done while the child is still in the program, not sent home with them, unless it is a serious matter. Behaviors considered inappropriate are, but not limited to:

- Fighting, Throwing things, Inappropriate language, Disrespect for others
- Refusing to listen to the teacher, Hitting, Biting or Kicking, children or teachers

A staff member will give positive guidance, redirection, setting clear limits to the child while maintaining good supervision of all areas. This allows the children to get control of their behavior and be able to continue to participate in classroom activities.

We do not use abusive, neglectful, physical restraint, unless such restraint is necessary to protect the health and safety of the child or others.

In the even that re-direction or positive guidance is not effective and /or the child has severely injured another child or teacher, a parent/guardian will be called in to discuss the situation and to develop a plan of action and /or 211 Info line may be called in for professional assistance depending on the severity of the behavior being exhibited.

I have read and understand the policy. The Behavior Management Plan has been discussed with me.

Child's First / Last Name ____

By signing this document, I affirm that I am the person legally responsible by law to make decisions for the well-being of the above named child.

Parent/Legal Guardian's Name/Signature ______________________________ Date: __________

01/05/2026

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CENTRAL CONNECTICUT COAST YMCA
Infant, Toddler, Preschool and SACC Summer Camp 2026
Authorization for Access/Release of Information

Camper's First Name ______________________ Last ________________________ Date______

Parent Legal Guardian Authorizations and Acknowledgements

I hereby authorize the CCC Y Preschool and School Age Child Care program and related entities to release and obtain (in either verbal or written form) information on my child to:
Name ____

Name ____

Name ____

- I understand that these transactions may include: standard reports, child/family history, physical reports, discharge summaries, growth charts, development continuum, immunization/lab reports and assessments.
  Initial __
- I understand that this authorization that I have signed is in effect the length of the child's enrollment in our program.
  Initial __
- I understand that if anyone other than those listed on this form request information, I will be notified by the program of this request and will have to provide authorization for any additional entities that are not listed above. This form will also need to be updated.
  Initial __

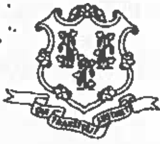
By signing this document, I affirm that I am the person legally responsible by law to make decisions for the well-being of the above named child.

Signature of Parent/Legal Guardian_______________________________Date________________

Relationship to Child_______________________________________

Signature of Program Staff___________________________________Date________________

CENTRAL CONNECTICUT COAST YMCA
1240 Chapel Street, New Haven, CT 06511
P 203 777 9622 F 203 773 8950 W cccymca.org



State of Connecticut Department of Education
Health Assessment Record

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part 1) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part 2) and the oral assessment (Part 3).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, licensed pursuant to chapter 378, physician assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity ❑ American Indian/ Alaskan Native ❑ Hispanic/Latino	❑ Black, not of Hispanic origin ❑ White, not of Hispanic origin ❑ Asian/Pacific Islander ❑ Other
Primary Care Provider		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N
Does your child have dental insurance? Y N

If your child does not have health insurance, call **1-877-CT-HUSKY**

* If applicable

Part 1 — To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

Please circle Y if "yes" or N if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				Y	N	Diabetes	Y	N
Any immediate family members have high cholesterol				Y	N	ADHD/ADD	Y	N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take **in** school:

*All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.*

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian Date

To be maintained in the student's Cumulative School Health Record

Part 2 — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name ______________________ Birth Date __________ Date of Exam __________

❑ I have reviewed the health history information provided in Part 1 of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

***Height**_____ in. /_____ % ***Weight**_____ lbs. /_____ % **BMI**_____/_____ % **Pulse** _____ ***Blood Pressure**_____/_____

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen			***Postural** ❑ No spinal abnormality	❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made	
Genitalia/ hernia					
Skin					

Screenings * According to Bright Future's Periodicity Schedule

***Vision Screening**

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Referral made

***Auditory Screening**

Type:	Right	Left
	❑ Pass	❑ Pass
	❑ Fail	❑ Fail

❑ Referral made

	Date
***History of Lead Level** ≥3.5 µg/dL ❑ No ❑ Yes **Results:**	
***Speech** (school entry only)	
***HCT/HGB:**	

TB: High-risk group? ❑ No ❑ Yes PPD date read: Results: Treatment:

*IMMUNIZATIONS

❑ Up to Date or ❑ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
*If yes, please provide a copy of the **Asthma Action Plan** to School*

Anaphylaxis Allergies ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Unknown source
*If yes, please provide a copy of the **Emergency Allergy Plan** to School*
History of Anaphylaxis ❑ No ❑ Yes Epi Pen required ❑ No ❑ Yes

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease:**

Seizures ❑ No ❑ Yes, type:

❑ This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
*Explain:*______________________

Daily Medications (*specify*): ______________________

This student may: ❑ **participate fully in the school program**
❑ participate in the school program with the following restriction/adaptation: ______________________

This student may: ❑ **participate fully in athletic activities and competitive sports**
❑ participate in athletic activities and competitive sports with the following restriction/adaptation: __________

❑ Yes ❑ No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
Is this the student's medical home? ❑ Yes ❑ No ❑ I would like to discuss information in this report with the school nurse.

Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Part 3 — Oral Health Assessment/Screening

Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	❑ Male ❑ Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination Completed by:	**Visual Screening** Completed by:	**Normal**	**Referral Made:**
❑ Dentist	❑ MD/DO ❑ APRN ❑ PA ❑ Dental Hygienist	❑ Yes ❑ Abnormal (Describe) __________ __________ __________ __________ __________	❑ Yes ❑ No

Risk Assessment	**Describe Risk Factors**	
❑ Low ❑ Moderate ❑ High	❑ Dental or orthodontic appliance ❑ Saliva ❑ Gingival condition ❑ Visible plaque ❑ Tooth demineralization ❑ Other __________	❑ Carious lesions ❑ Restorations ❑ Pain ❑ Swelling ❑ Trauma ❑ Other __________

Recommendation(s) by health care provider: ______________________________

____

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

____

Signature of Parent/Guardian Date

____

Signature of health care provider DMD / DDS / MD / DO / APRN / PA/ RDH Date Signed Printed/Stamped *Provider* Name and Phone Number

Student Name: ______________________ **Birth Date:** ______________ HAR-3 REV. 3/2024

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap	*				Required 7th-12th grade	
IPV/OPV	*	*	*			
MMR	*	*			Required K-12th grade	
Measles	*	*			Required K-12th grade	
Mumps	*	*			Required K-12th grade	
Rubella	*	*			Required K-12th grade	
HIB	*				PK and K (Students under age 5)	
Hep A	*	*			See below for specific grade requirement	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			Required K-12th grade	
PCV	*				PK and K (Students under age 5)	
Meningococcal	*				Required 7th-12th grade	
HPV						
Flu	*				PK students 24-59 months old – given annually	
Other						

Disease Hx of above ______________ (Specify) ______________ (Date) ______________ (Confirmed by)

Religious Exemption: __________

Religious exemptions must meet the criteria established in Public Act 21-6: https://portal.ct.gov/-/media/SDE/Digest/2020-21/CSDE-Guidance---Immunizations.pdf.

Medical Exemption: __________

Must have signed and completed medical exemption form attached. https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/infectious_diseases/immunization/CT-WIZ/CT-Medical-Exemption-Form-final-09272021fillable3.pdf

KINDERGARTEN THROUGH GRADE 6

- DTaP: At least 4 doses, with the final dose on or after the 4th birthday; students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after the1st birthday (children 5 years and older do not need proof of vaccination).
- Pneumococcal: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the1st birthday or verification of disease.**

GRADES 7 THROUGH 12

- Tdap/Td: 1 dose of Tdap required for students who completed their primary DTaP series; for students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are required, one of which must be Tdap.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Meningococcal: 1 dose
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.

HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES

- August 1, 2017: Pre-K through 5th grade
- August 1, 2018: Pre-K through 6th grade
- August 1, 2019: Pre-K through 7th grade
- August 1, 2020: Pre-K through 8th grade
- August 1, 2021: Pre-K through 9th grade
- August 1, 2022: Pre-K through 10th grade
- August 1, 2023: Pre-K through 11th grade
- August 1, 2024: Pre-K through 12th grade

** **Verification of disease:** Confirmation in writing by an MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

Note: The Commissioner of Public Health may issue a temporary waiver to the schedule for active immunization for any vaccine if the National Centers for Disease Control and Prevention recognizes a nationwide shortage of supply for such vaccine.

Initial/Signature of health care provider MD / DO / APRN / PA ______ Date Signed ______ Printed/Stamped *Provider* Name and Phone Number ______

Application & Supporting Documents Checklist

Thank you for completing the Care 4 Kids (C4K) Application. In order to complete your application, please be sure to submit the following required documents:

☐ **Parent Provider Agreement Form (4 pages)**

- Required with all applications and redeterminations.
- To be completed by you and the child care provider.
- If your child care provider is new to Care 4 Kids, the provider's W-9 is required.
- All new C4K providers must complete all orientation requirements for program staff prior to applying for C4K. See the C4K website for provider requirements – Provider Requirements – CT Care 4 Kids
- Providers will be eligible for payment the day after the training is completed.
- If you need help finding a provider, call 2-1-1 Child Care at 2-1-1 or 1-800-505-1000.

If **currently employed**, the following are required for you and the other legal parent in your home (if applicable):

☐ **Existing Employment Income Verification (e.g. pay stubs, employer letter)**

- If paid weekly, submit the last 4 pay stubs
- If paid bi-weekly or semi-monthly, submit the last 2 pay stubs
- If paid monthly or annually, submit the last 1 pay stub

If **beginning new employment**, the following are required for you and the other legal parent in your home (if applicable):

☐ **New Employment Verification (Letter from Employer)**

- Letters must be completed by the employer and contain the following:
  - Current date
  - Employment start date
  - Average weekly hours
  - Gross earnings
  - Title and contact phone number of the individual preparing the letter

If **self-employed**, the following are required for you and the other legal parent in your home:

☐ **Self-Employment Verification**

- Most recent signed and dated IRS tax forms (1040, Schedule 1 and Schedule C); or
- Self-Employment Business Form (can be found at https://www.ctcare4kids.com/wp-content/uploads/2025/03/Self-Employment-Form-English2025.pdf); and
- Business records including business income and expenses.

care4kids
MAKING CHILD CARE AFFORDABLE

If a parent is **disabled**, the following form is required:

- ☐ Disability Form (can be found at https://www.ctcare4kids.com/wp-content/uploads/2021/03/Disability-Verification-Form.pdf)

If child(ren) have **special needs**, the following form is required for any children with special needs:

- ☐ Special Needs Verification Form (can be found at https://www.ctcare4kids.com/wp-content/uploads/2019/11/Special-Needs-Verification-Form.pdf)

If **participating in a higher education, general educational diploma (GED)/high school equivalency, or workforce development/training program, the following are required for you and the other legal parent in your home (if applicable):

☐ **Higher Education** ☐ **GED** ☐ **Workforce Development/Training program**

- Written verification of enrollment from the educational institution/training program including current class schedule. This written verification must include, at a minimum:
  - Parent's name and enrollment date.
  - Name of the institution, contact person, and contact information (phone number).
  - If not included on the class schedule, the written statement must also include either the number of credit hours or the number of in-class or online hours per week.

If any or all apply, the following are required for anyone who lives in your home:

- ☐ **Social Security Income –** current award notice, copy of current check or statement from Social Security Administration.
- ☐ **Child Support Paid** – cancelled check, money order, or wage stub showing deduction for child support paid to an adult not living in your home.
- ☐ **Foster Care Payment –** current foster care stipend check stub or award letter from the Department of Children and Families.
- ☐ **Rental Income You Receive From Someone Else –** business records or income tax records.

Missing and/or incomplete forms will not be accepted and WILL DELAY PROCESSING.

care4kids
MAKING CHILD CARE AFFORDABLE

Care 4 Kids Application

Care 4 Kids ▪ 55 Capital Boulevard ▪ Rocky Hill, CT 06067
Phone: 1-888-214-5437
Fax: 1-877-868-0871

SECTION 1: APPLICANT INFORMATION/HEAD OF HOUSEHOLD

The applicant is the parent or adult legally responsible for the child(ren). If the parent is under the age of 18 and living with an adult, the adult is considered the applicant and must fill out and sign this Application.

FIRST NAME ____ *M.I.* ____ *LAST NAME* ____ *DATE OF BIRTH* ___/___/___

STREET ADDRESS ____ *FLOOR/APARTMENT NUMBER* ____

CITY ____ *STATE* ____ *ZIP* ____ *CELL PHONE* ( ) ____ *WORK PHONE* ( ) ____

SOCIAL SECURITY NUMBER (OPTIONAL) ___-___-___ *E-MAIL ADDRESS* ____

Gender: ❑ **F** (Female) ❑ **M** (Male)

Marital Status: ❑ Married ❑ Single ❑ Separated ❑ Divorced

Race: ❑ **A** (Asian) ❑ **B** (Black/African) ❑ **C** (White) ❑ **N** (American Indian/Alaska Native)
❑ **P** (Native Hawaiian/Other Pacific Islander) ❑ I prefer not to answer

Hispanic/Latino: ❑ YES ❑ NO ❑ I prefer not to answer

Does your household have assets that exceed $1 million in value? ❑ YES ❑ NO

Is this Application for child care assistance for a foster child? ❑ YES ❑ NO

Are you living in a temporary housing situation? ❑ YES ❑ NO

Have you moved 3 or more times in the past year? ❑ YES ❑ NO

Are you an active member of the United States Military? ❑ YES ❑ NO (If **YES**, check box below)
❑ Active Duty U.S. Military ❑ National Guard Military Reserve

Do you have an impairment that requires an accommodation or extra help completing this application? ❑ YES ❑ NO

What is the primary language spoken in your home? ____________________

❑ Marque aquí si desea recibir cartas y formularios en español. *(Check here to receive letters and forms in Spanish)*

SECTION 2: INFORMATION ON THE OTHER PARENT LIVING IN YOUR HOME

You MUST list your spouse, civil union partner or other legal parent of your children that live in your home.

First Name, Middle Initial, Last Name	Date of Birth	Gender	Relationship to Applicant	Social Security Number (*optional*)	Is this person a parent of a child living in the home?
1.	___/___/___	❑ M ❑ F		___-___-___	❑ YES ❑ NO Name of Child ________

Is the adult listed above an active member of the United States Military? ❑ YES ❑ NO If **YES**, check box below:
❑ Active Duty U.S. Military ❑ National Guard Military Reserve

NAME (First/Last): ____________________

SECTION 3: CHILDREN INFORMATION

Please list all children under the age of 18 that live in the home. To be eligible for child care assistance, children must be under age 13. Children with special needs may be eligible under age 19.

KEY: A (Asian) B (Black/African Descent) C (White) N (American Indian/Alaskan Native) P (Native Hawaiian/Other Pacific Islander) NA (I prefer not to answer)

Child's Name *(First Name, Middle Initial, Last Name)*	Child Care Needed?	Date of Birth	Relationship to Applicant	Gender	Race *(circle all that apply)*	Is child Hispanic /Latino?	Social Security Number *(optional)*	Citizenship Status	Is child up to date with shots? *(immunizations)*
1.	☐ YES ☐ NO	__/__/__		☐ M ☐ F	A B C N P NA	☐ YES ☐ NO ☐ NA	___-___-___	☐Citizen ☐Permanent Resident ☐Other	☐ YES ☐ NO
2.	☐ YES ☐ NO	__/__/__		☐ M ☐ F	A B C N P NA	☐ YES ☐ NO ☐ NA	___-___-___	☐Citizen ☐Permanent Resident ☐Other	☐ YES ☐ NO
3.	☐ YES ☐ NO	__/__/__		☐ M ☐ F	A B C N P NA	☐ YES ☐ NO ☐ NA	___-___-___	☐Citizen ☐Permanent Resident ☐Other	☐ YES ☐ NO
4.	☐ YES ☐ NO	__/__/__		☐ M ☐ F	A B C N P NA	☐ YES ☐ NO ☐ NA	___-___-___	☐Citizen ☐Permanent Resident ☐Other	☐ YES ☐ NO
5.	☐ YES ☐ NO	__/__/__		☐ M ☐ F	A B C N P NA	☐ YES ☐ NO ☐ NA	___-___-___	☐Citizen ☐Permanent Resident ☐Other	☐ YES ☐ NO

Do any of the children listed above have special needs? ☐ YES ☐ NO **If YES**, provide the name(s) of the child(ren):

____

____

Do you share joint custody with any of the children listed above? ☐ YES ☐ NO

If **YES**, provide the name(s) of the child(ren): ____________________

Do any of the children listed above have their *own* children living in your home? ☐ YES ☐ NO If **YES**, list the names of the minor parents (under age 18) and the name(s) of their child(ren):

Parent(s) Under Age 18:	**Child(ren) of Parent Under Age 18:**
____________________	____________________
____________________	____________________

SECTION 4: WORK/TRAINING ACTIVITY AND INCOME INFORMATION

Fill out the information below for all parents in the home. **If there are more than 2 activities, make a copy of this page or download and print another copy of this page from the Care 4 Kids website at www.ctcare4kids.com.**

Complete the following information about <u>your</u> work/training activity.

____

NAME OF PARENT IN THE HOME

Type of Activity: ☐ Work ☐ High School ☐ Self-Employed ☐ Training or Education approved by JFES
☐ Higher Education ☐ GED/Adult Education ☐ Workforce Development/Training program

Name of Employer/Business/Program/School ____________________

Employer Industry/Type of Work (i.e. retail, construction, real estate, contractor, etc.) ____________________

Address ____________________ City____________________ State ________ Zip________

Start Date ____________________ Phone (______) ____________________

NAME (First/Last):______________________________

SECTION 4, CONTINUED: WORK/TRAINING ACTIVITY AND INCOME INFORMATION

How frequently do you get paid? ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

On average, how many **hours per week** do you work or participate in an activity? ______________

On average, how many **days per week** do you work or participate in an activity? ______________

How much do you get paid before taxes are deducted (gross income)? $______________

☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Semi-Monthly ☐ Monthly ☐ Annually

If you are self-employed, how much do you get paid before taxes and expenses are deducted (gross income)? $__________

☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Semi-Monthly ☐ Monthly ☐ Annually

If you are self-employed, how much are your expenses (dollar amount)? $ ______________

☐ Weekly ☐ Bi-weekly ☐ Semi-Monthly ☐ Monthly ☐ Annually

What is your daily roundtrip commute from child care setting to work/activity? ☐ None ☐ 1-30 minutes ☐ 31-60 minutes ☐ More than 60 minutes

Do you take public transportation? ☐ YES ☐ NO

☐ Unable to provide care due to significant physical or mental condition, disability or impairment that is expected to last for at least one calendar month. (Verification will be required)

If the other parent in the household is working or in a training activity, or if you have a second activity, complete the following information:

____

NAME OF OTHER PARENT IN THE HOME

Type of Activity: ☐ Work ☐ High School ☐ Self-Employed ☐ Training or Education approved by JFES ☐ Higher Education ☐ GED/Adult Education ☐ Workforce Development/Training program

Name of Employer/Program/School______________________________

Employer Industry/Type of Work (i.e. retail, construction, real estate, contractor, etc.) ______________

Address______________________ City______________ State________ Zip________

Start Date______________________ Phone (____)______________

How frequently do you get paid? ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

On average, how many **hours per week** do you work or participate in an activity? ______________

On average, how many **days per week** do you work or participate in an activity? ______________

How much do you get paid before taxes are deducted (gross income)? $______________

☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Semi-Monthly ☐ Monthly ☐ Annually

If you are self-employed, how much do you get paid before taxes and expenses are deducted (gross income)? $__________

☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Semi-Monthly ☐ Monthly ☐ Annually

If you are self-employed, how much are your expenses (dollar amount)? $ ______________

☐ Weekly ☐ Bi-weekly ☐ Semi-Monthly ☐ Monthly ☐ Annually

What is your daily roundtrip commute from child care setting to work/activity? ☐ None ☐ 1-30 minutes ☐ 31-60 minutes ☐ More than 60 minutes

Do you take public transportation? ☐ YES ☐ NO

☐ Unable to provide care due to significant physical or mental condition, disability or impairment that is expected to last for at least one calendar month. (Verification will be required)

NAME (First/Last):____

SECTION 5: CHILD SUPPORT PAID AND ADDITIONAL INCOME INFORMATION

Does anyone living in your home **pay child support?** ☐ YES ☐ NO **If Yes,** submit verification of child support payment.
How much is paid? $__________________ How often? ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

Does anyone living in your home receive a **DCF stipend?** ☐ YES ☐ NO If **Yes**, who receives it? __________________
How much is received? $__________________ How often? ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

Does anyone living in your home receive **unemployment compensation?** ☐ YES ☐ NO If **Yes,** who receives it? ____________
How much is received? $__________________ How often? ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

Does anyone living in your home receive **Social Security Income?** ☐ YES ☐ NO If **Yes,** who receives it? ______________
How much is received? $__________________ How often? ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

Do you receive **child care assistance from another source?** ☐ YES ☐ NO If **Yes**, from whom?__________________________
How much? $__________________ How often? ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

Does anyone living in your home receive **any other income** (i.e. alimony, pensions, workers' compensation, veteran benefits, rental income)? ☐ YES ☐ NO If **Yes,** who receives it?__________________ What type of income? __________________
How much? $__________________ How often? ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

SECTION 6: PARENTS RIGHTS AND RESPONSIBILITIES

Please read the following section carefully. If there is anything you do not understand, call **Care 4 Kids at 1-888-214-5437.**

- When you have read this section, **please sign and date** the next page.
- You have the right to file an Application, withdraw an Application, or discontinue your participation in Care 4 Kids at any time.
- You have the right to be treated fairly by Care 4 Kids without regard to race, color, religion, sex or sexual orientation, marital status, national origin, ancestry, age, political beliefs, or disability.
- You have the right to request forms and notices in Spanish. All non-English speaking participants have the right to the services of an interpreter.
- You have the right to ask for a review of any decision made by Care 4 Kids on your Application. You have the right to speak to a supervisor or mediator and the right to request a hearing from the State of Connecticut.

I understand and agree that:

- I must report changes in my situation to Care 4 Kids **within 10 days** of the change for the following: change in address, household income over 85% of the State Median Income, if the child receiving Care 4 Kids benefits is no longer in the home, change child care provider, and loss of employment or stopping an approved activity. For the current State Median Income Chart, please visit the Care 4 Kids website www.ctcare4kids.com.
- Care 4 Kids may verify the information I have given on this form. I understand that if I am eligible for Care 4 Kids, benefits will not begin any earlier than 15 days before the date the Application is received.
- With my signature, I hereby give voluntary consent for the Department of Social Services (DSS) to share with the Office of Early Childhood (OEC) confidential information retained by DSS about myself and minor household members, to be used by the OEC to determine eligibility and the level of benefits for the Child Care Assistance Program (CCAP). The OEC will obtain confidential information from DSS only under circumstances allowed by state and federal law. I understand that the OEC may share this confidential information with the CCAP administrator, Care 4 Kids. Confidential information obtained from DSS will be used solely for the purpose of CCAP eligibility and benefits and will not be disseminated outside the OEC or the CCAP administrator, or in violation of federal or state law. I understand that my DSS benefits will not be affected by this consent, and I may revoke this authorization at any time by sending a written request to the OEC, 450 Columbus Boulevard, Suite 303, Hartford, CT 06103. This authorization automatically expires one year from the date of application.
- The Department of Labor will share unemployment compensation and wage information for applicants and household members for determination of eligibility for Care 4 Kids. The Connecticut Office of Early Childhood (OEC) may disclose to its contractor confidential information from the Department of Labor concerning unemployment compensation benefits and quarterly wage information pertaining to individuals who have signed the Application, only as necessary, to determine eligibility for the Care 4 Kids program.
- The information on this form is confidential. The OEC or its contractor will only use this information to administer a State of Connecticut program. Information may be shared with others as permitted by law.
- Care 4 Kids will disclose information about my eligibility for Care 4 Kids to my provider.
- Care 4 Kids may be required to provide information about program applicants and participants to law enforcement officials.
- The child care arrangement is between my provider and me. The OEC and Care 4 Kids are not responsible for the child care arrangement.

SECTION 6, CONTINUED: PARENTS RIGHTS AND RESPONSIBILITIES

- The State of Connecticut may conduct unscheduled visits to verify any household, employer, or provider circumstances.
- Care 4 Kids may not pay the full amount charged by my provider. I am responsible for paying all additional provider charges.
- I have the right to choose any eligible child care provider that meets all applicable health, training, and licensing requirements.
- I understand that if I am eligible for Care 4 Kids, benefits will not start until all information is received and verified.
- I may be required to repay any benefits received in error, including administrative errors. I may be subject to criminal prosecution for fraud if I knowingly supply any false information to Care 4 Kids or fail to report changes on time. I also may be disqualified from the program. In order to remain eligible, I must cooperate with the Care 4 Kids and State of Connecticut quality control process.

RELEASE OF INFORMATION FOR RESEARCH PURPOSES (please make a selection below):

I understand that the Office of Early Childhood (OEC) may share information about the parent(s), minor child(rent), and caregivers listed on this application. The OEC may share this information for research purposes and/or to evaluate Care 4 Kids program effectiveness. Information that may be disclosed and shared includes but is not limited to Personally Identifiable Information (PII) or Personal Health Information (PHI) provided on the application and/or collected as part of the administration of the Care 4 Kids program.

PLEASE NOTE: Your consent to the sharing of this information is not a prerequisite for eligibility or enrollment in the Care 4 Kids program and you may withdraw your consent at any time.

☐ **I agree to this release of information.**

☐ **I do not agree to this release of information.**

PLEASE READ AND SIGN: I have read my rights and responsibilities or have had them read to me in a language I understand. I certify, under penalty of perjury, that all of the information provided is true and correct to the best of my knowledge.

Applicant Signature:______________________________________ Date:____________________

Signature of other legally responsible adult living with you (i.e. spouse, child's other parent, etc.)

Other Signature:______________________________________ Date:____________________

RETURN THIS APPLICATION TO CARE 4 KIDS
ONLINE: https://www.ctcare4kids.com/upload/
MAIL OR DROP-OFF: Care 4 Kids ▪ 55 Capital Boulevard ▪ Rocky Hill, CT ▪ 06067
FAX: 1-877-868-0871

Si quiere recibir este formulario en español, llame al 1-888-214-5437.

Summer Parent-Provider Agreement Form

This form tells us about the child care arrangement.

Step 1: This form must be completed by the parent **and** the child care provider.
- **Parent** – Complete Sections 1, 3 and 5.
- **Child Care Provider** – Complete Sections 2, 3 and 4.

Step 2: Make sure all sections have been filled in and the information is correct. Answer all Yes or No questions by checking the right box. Once you have filled out and checked this form, make sure the parent and provider sign and date this form. If you need help, call 1-888-214-5437 or visit www.ctcare4kids.com. **Incomplete forms may not be accepted and will delay processing.**

Step 3: All Care 4 Kids (C4K) providers **must complete** all orientation and annual training requirements prior to receiving payments. See the C4K website for provider requirements: Provider Requirements – CT Care 4 Kids

Step 4: The law requires us to report all payments to the Internal Revenue Service (IRS) for income tax purposes. If you are a new child care provider with Care 4 Kids (C4K), you must provide us with your Social Security Number or Federal Employer Identification Number and fill out an IRS W-9 form. To get a W-9 form by mail, call 1-888-214-5437, or download the form at www.ctcare4kids.com. If you have already submitted a W-9 form to us, you do not need to fill out a new form unless your information has changed. Care 4 Kids does not withhold income taxes. Providers are responsible for paying taxes to the IRS and the State of Connecticut.

Step 5: Submit the completed form to: **Care 4 Kids, 55 Capital Boulevard, Rocky Hill, CT 06067** or fax it to: **1-877-868-0871.**

SECTION 1: PARENT INFORMATION *(To be completed by Parent)*

Parent Name:______________________________ C4K Case Number:____________
Last Name, First Name, Middle Initial

Parent Address:____________________ City, State, Zip Code:________________

Telephone Number: (Cell)________________ (Secondary)________________

Reason for submitting this form: ☐ Part of my Application or Redetermination ☐ Reporting changes or a new provider

SECTION 2: CHILD CARE PROVIDER INFORMATION *(To be completed by Provider)*

What type of child care provider are you?
- ☐ Unlicensed Individual (relative)
- ☐ Licensed Family Child Care Home
- ☐ Licensed Child Care Center
- ☐ Licensed Group Child Care Home
- ☐ Licensed Youth Camp
- ☐ Exempt Youth Camp
- ☐ Exempt Center Based Program

Are you accredited by any of the following? (*check if yes*)
- ☐ National Assoc. for the Education of Young Children (NAEYC)
- ☐ Council on Accreditation (COA)
- ☐ New England Assoc. of Schools and Colleges (NEASC)
- ☐ National Assoc. for Family Child Care (NAFCC)

SECTION 2A: LICENSED CHILD CARE PROVIDERS/EXEMPT PROGRAMS *(To be completed by Provider)*

PROVIDER NAME

Center Name:____________________ Licensed Home:________________
(Last) (First)

Address where child care is provided:______________________________
Street City State Zip Code

Telephone Number: (Cell)________________ (Secondary)________________

Date of Birth:__________ C4K Provider ID:__________ License Number:__________
Family Home Providers Only

Please list the address you would like notices to be mailed if different from the address where child care is provided:

Street Address:____________________ City, State, Zip Code:________________

Parent Name:	C4K Case Number:

SECTION 2A, CONTINUED: LICENSED CHILD CARE PROVIDERS/EXEMPT PROGRAMS *(To be completed by Provider)*

☐ I understand I must complete the pre-service orientation/training requirement prior to becoming eligible for payment. Providers will be eligible for payment the day after the training is completed. For more information, visit www.ctcare4kids.com.

☐ I understand that all licensed child care and exempt programs must complete all health and safety requirements in order to become and remain an eligible child care provider.

SECTION 2B: UNLICENSED RELATIVE CHILD CARE PROVIDERS *(To be completed by Provider)*

You must be related to the child by blood, marriage, or adoption. This means the child is your grandchild, great grandchild, niece, nephew, or sibling. If you are not related, you must have a license from the Office of Early Childhood Division of Licensing to provide child care.

Provider Name:____
Last Name, First Name, Middle Initial

Home Address:______________________________ City, State, Zip Code:______________________

Telephone Number: (Cell)________________________ (Secondary)________________________

C4K Provider ID:______________________________

Date of Birth:_______/_______/_______ Gender: ☐ Male ☐ Female

☐ I understand I must complete the pre-service training requirement prior to becoming eligible for payment. For more information, visit www.ctcare4kids.com.

Are you self-employed or do you have another job other than providing child care? ☐ YES ☐ NO If yes, enter your work schedule at your other job in the table below.

Name, Address, and Telephone Number of your other job:____

____

Provider: Use this table to enter the hours and days you normally work your other job (circle AM or PM).

TIME	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
Start	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM
End	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM

Where do you provide child care for the children listed on this agreement form? ☐ Child's home ☐ Provider's home ☐Other_______

Is there a working telephone at this care location? ☐ YES ☐ NO Telephone number: (_____)______________________

Is there a working smoke detector? ☐ YES ☐ NO Do you have immediate access to a fire extinguisher? ☐ YES ☐ NO

What is the total number of children in your care at the same time on any day, including your own children?______________

How many of these children are under the age of 2, including your own children?______________________

Are you under investigation by the Department of Children and Families (DCF) for child abuse or child neglect or do you have a record of child abuse or child neglect in Connecticut or any other state? ☐ YES ☐ NO

Were you ever arrested, or do you have an arrest warrant or criminal charge pending against you? ☐ YES ☐ NO

What crime(s) were you charged with? When and where?______________________________________

Have you ever been convicted of any of the crimes listed below? ☐ YES ☐ NO

- Abandonment, injury, or risk of injury to a minor.
- Cruelty to persons or animals, stalking, obscenity, public indecency, reckless endangerment, arson, robbery, burglary, home invasion.
- Use of force against another person, including murder, assault, manslaughter, kidnapping, unlawful restraint.
- Crimes involving a weapon, explosives, or a firearm.
- Sex crimes including sexual assault, rape, prostitution, child pornography, and other related sex crimes.
- Sale, manufacture, or possession of narcotics or other illegal drugs or controlled substances.

For a complete crime list please visit www.ctcare4kids.com

NOTE: All Unlicensed Relative Providers are subject to child abuse/neglect, sex offender, and criminal background checks. If the results of the background check confirm you are ineligible, you will be required to repay Care 4 Kids benefits issued to you.

Parent Name:	C4K Case Number:

SECTION 3: CHILDREN IN CARE *(To be completed together by Parent and Provider)*

***Complete for each child needing Care 4 Kids assistance.** If there are more than 3 children in your care, make a copy of this page or download and print another copy of this page from the Care 4 Kids website at www.ctcare4kids.com.*

CHILD #1

______________________ ______________________ ______ ____/____/____

LAST NAME *FIRST NAME* *M.I.* *DATE OF BIRTH*

Summer Care: Date care started:__________ Date care ended:__________ How much is the parent charged per week? $__________

Will Child 1 stay with this provider in the Fall and will the before/after school hours of care remain the same? ☐ Yes ☐ No

Are you currently charging a mandatory registration fee for this child? ☐ YES ☐ NO If yes, how much is the registration fee? $__________

Are you related to this child? ☐ YES ☐ NO **If related, specify your relationship to the child:**

☐ Grandparent/Great Grandparent ☐ Aunt/Uncle ☐ Sibling ☐ Other: ______________

CHILD CARE SCHEDULE: Fill in the time the child is in your care (circle AM or PM)

Day of the Week	Schedule 1 Begin Time	Schedule 1 End Time	Schedule 2 Begin Time	Schedule 2 End Time
Sunday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Monday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Tuesday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Wednesday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Thursday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Friday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Saturday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM

Is this child care schedule the same each week? ☐ YES ☐ NO If no, explain how the care schedule varies:______________

CHILD #2

______________________ ______________________ ______ ____/____/____

LAST NAME *FIRST NAME* *M.I.* *DATE OF BIRTH*

Summer Care: Date care started:__________ Date care ended:__________ How much is the parent charged per week? $__________

Will Child 2 stay with this provider in the Fall and will the before/after school hours of care remain the same? ☐ Yes ☐ No

Are you currently charging a mandatory registration fee for this child? ☐ YES ☐ NO If yes, how much is the registration fee? $__________

Are you related to this child? ☐ YES ☐ NO **If related, specify your relationship to the child:**

☐ Grandparent/Great Grandparent ☐ Aunt/Uncle ☐ Sibling ☐ Other: ______________

CHILD CARE SCHEDULE: Fill in the time the child is in your care (circle AM or PM)

Day of the Week	Schedule 1 Begin Time	Schedule 1 End Time	Schedule 2 Begin Time	Schedule 2 End Time
Sunday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Monday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Tuesday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Wednesday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Thursday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Friday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Saturday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM

Is this child care schedule the same each week? ☐ YES ☐ NO If no, explain how the care schedule varies:______________

Parent Name:	C4K Case Number:

SECTION 3, CONTINUED: CHILDREN IN CARE *(To be completed together by Parent and Provider)*

CHILD #3

______________________ ______________________ ______ ____/____/____
LAST NAME *FIRST NAME* *M.I.* *DATE OF BIRTH*

Summer Care: Date care started:__________ Date care ended:__________ How much is the parent charged per week? $__________

Will Child 3 stay with this provider in the Fall and will the before/after school hours of care remain the same? ☐ Yes ☐ No

Are you currently charging a mandatory registration fee for this child? ☐ YES ☐ NO If yes, how much is the registration fee? $__________

Are you related to this child? ☐ YES ☐ NO **If related, specify your relationship to the child:**

☐ Grandparent/Great Grandparent ☐ Aunt/Uncle ☐ Sibling ☐ Other: ______________

CHILD CARE SCHEDULE: Fill in the time the child is in your care (circle AM or PM)

Day of the Week	Schedule 1 Begin Time	Schedule 1 End Time	Schedule 2 Begin Time	Schedule 2 End Time
Sunday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Monday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Tuesday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Wednesday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Thursday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Friday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Saturday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM

Is this child care schedule the same each week? ☐ YES ☐ NO If no, explain how the care schedule varies:______________________

SECTION 4: PROVIDER CERTIFICATION *(To be completed by Provider)*

I certify that:

1) I am the individual or program that is providing care to the children listed on this form. I am at least 20 years of age and capable of providing safe and competent child care services. I do not have a disability, impairment or health problem that would prevent me from caring for the children.
2) Care will be given at the location specified on the form. I am responsible for reporting changes in the hours of care, the amount I charge for services, if the child stops attending care, and changes in the location where care is given. I must also inform Care 4 Kids of any changes in my criminal or child abuse/neglect history. Changes must be reported within 10 days.
3) For each child in my care, I have the name of the child's primary care physician and health insurance provider and proof that each child is up to date with his or her immunizations and health screening exams.
4) I understand and agree that the Office of Early Childhood and Care 4 Kids may verify information listed on this form independently without prior authorization, including criminal and child abuse/neglect background checks.
5) I understand that this agreement is between the parent and the provider. It is not a contract with Care 4 Kids or the State of Connecticut. Neither Care 4 Kids nor the State of Connecticut employ me. I am an independent contractor and will receive a 1099 tax form for monies received from Care 4 Kids.
6) Care 4 Kids may not cover my total charges. The parent is responsible for any costs that are not paid by Care 4 Kids.
7) I may be required to repay benefits that were paid to me in error. I may also be subject to criminal or civil charges if I knowingly omit, misrepresent, or provide false information to Care 4 Kids or if I do not report changes in a timely manner that affect payments or my eligibility for this program. I may be liable for all penalties associated with crimes, including, but not limited to, larceny by defrauding a public community, conspiracy to commit larceny by defrauding a public community, vendor fraud, forgery, false statement, and other relevant crimes pursuant to Title 53a of the Connecticut General Statutes.
8) I must submit a completed invoice to receive payment. Invoices are issued to me when payment is approved and monthly thereafter. I will have **120 days** to submit the completed invoice in order to be paid.
9) To be eligible for payments, (1) I will abide by State of Connecticut health and safety regulations as applied to me (either as a licensed or unlicensed provider), and (2) I will cooperate with the State of Connecticut and its designees in program audits and fraud prevention activities, including any site visits that may be conducted to my home, child care site or place of employment.
10) I understand I must complete the orientation and annual training requirements in order to be eligible for payment. For more information on specific provider requirements, visit www.ctcare4kids.com.
11) I have read and understand the information contained in this form and certify that all of the information I have provided is true and correct to the best of my knowledge.
12) I understand that if I am licensed, I must report any child fatalities and any injuries that result in a child being admitted to a hospital that occur while a child is in my care to The Office of Early Childhood, Licensing Division at 1-800-282-6063.

Provider Name (*please print*):______________________ ______________________ ______
LAST NAME ***FIRST NAME*** ***M.I.***

Provider Signature:______________________________ ____/____/____
DATE

Parent Name:	C4K Case Number:

SECTION 5: PARENT CERTIFICATION *(To be completed by Parent)*

I certify that:

1) I have selected the provider identified above to care for my children while I work or attend an approved activity.
2) I will report any changes in child care arrangements, household income that exceeds 85% of the State Median Income guidelines, loss of a job or ending of an approved activity, if the child receiving Care 4 Kids benefits is no longer in the home, or my residential address to Care 4 Kids within 10 days of a change.
3) I am responsible to pay the provider any costs not covered by Care 4 Kids.
4) I understand and agree that Care 4 Kids may contact the provider listed above and the provider may contact Care 4 Kids concerning my eligibility and payment amounts.
5) I understand my provider must complete the orientation and annual training requirements in order to be eligible for payment. For more information on specific provider requirements, visit www.ctcare4kids.com.
6) I may be required to repay benefits that were paid in error on my behalf. I may also be subject to criminal or civil charges if I knowingly omit, misrepresent, or provide false information to Care 4 Kids or if I do not report changes in a timely manner that affect payments or my eligibility for this program. I may be liable for all penalties associated with crimes, including, but not limited to, larceny by defrauding a public community, conspiracy to commit larceny by defrauding a public community, vendor fraud, forgery, false statement, and other relevant crimes pursuant to Title 53a of the Connecticut General Statutes.

Parent Name (*please print*):____________________ ____________________ _____

LAST NAME ***FIRST NAME*** ***M.I.***

Parent Signature:__________________________________ ____/____/____

DATE

RETURN THIS FORM TO CARE 4 KIDS

ONLINE: https://www.ctcare4kids.com/upload/

MAIL OR DROP-OFF: Care 4 Kids ▪ 55 Capital Boulevard ▪ Rocky Hill, CT ▪ 06067

FAX: 1-877-868-0871

CENTRAL CONNECTICUT COAST YMCA
CONFIDENTIAL
FINANCIAL ASSISTANCE APPLICATION

The Central Connecticut Coast YMCA offers financial assistance for programs to qualified members. We are community based and believe that our programs should be available to everyone and that no one should be turned away because of their inability to pay. Our Financial Assistance Program is made possible because caring people and businesses in our communities fund the program through our Annual Campaign. Financial Assistance is available on a sliding scale that is based on total household income, family size and number of participants for a specific program.

It's easy to apply:

1. Please circle the program for which you would like financial assistance. One program per application.
2. Complete both sides of the application, including name and contact details, household members, and itemized income information. Please include any registration materials for the program(s) for which you are requesting financial assistance.
3. Child Care and Summer Camp applicants must also complete the CT Department of Social Services Care-4-Kids application in order for this application to be processed or reviewed.
4. A copy of your most recent Internal Revenue Service tax statement (tax return) and the last three pay stubs of all working adults must be included to process the application. Your SSI Allocation statement, DSS budget worksheet and any unemployment documents (if applicable) must also be included. Include any other documentation that supports your current income. (This information will be held confidential).
5. If you need assistance completing the application, please work with our Member Service Team.

Program: Child Care Camp Aquatics Youth/Teen Other:______________________________

Have you previously applied for financial assistance at the YMCA? Yes No If yes, which YMCA? ______________________

Today's Date____________________

Your Name ____Date of Birth______________

Address_______________________________________Email ______________________________

City____State__________Zip Code________________

Home Phone____________________Work Phone____________________Cell Phone____________________

Place of Current Employment____________________________________Length of Employment ___________

Program Participant(s)

Last Name	First Name	Date of Birth

Household Members (List all – adults and youth)

Last Name	First Name	Date of Birth

CENTRAL CONNECTICUT COAST YMCA
CONFIDENTIAL FINANCIAL ASSISTANCE APPLICATION page 2

Household Income	Monthly
Wages, Salaries & Tips (all sources in household)	$
Unemployment Compensation	$
Social Security Compensation	$
Disability Compensation	$
Child Support	$
Alimony	$
Aid to Dependent Children	$
Food Stamps	$
Housing Assistance	$
Utility Assistance	$
401K/Retirement	$
	$

If necessary, include documentation of any special expenses, extenuating circumstances, or crisis expense situations of which we should be aware.

Total amount you feel you can pay per month for program fees. $_______________
An amount must be entered or the application will not be processed.

REMEMBER: A copy of the most recent Internal Revenue Service tax statement (tax return) and the last three pay stubs of all working adults must be included for this application to be processed. Your SSI Allocation statement, DSS budget worksheet and any unemployment documents (if applicable) must also be included. You may choose to include your W-2's, and/or any other documentation that supports your current income. (This information will be held confidential). Child Care and Summer Camp applicants must also complete the Department of Social Services Care-4-Kids application and return it with this application in order for this application to be processed or reviewed.

I certify that the above information is true and complete to the best of my knowledge. If requested, I will provide further substantiation of all facts included above. I understand that applications take at least two weeks to process, after which a YMCA representative will contact me. I acknowledge that an incomplete application will not be processed.

Applicant's Name (print)____

Applicant's Signature____

Office Use Only
Date Received:____________________________
Program:____________________________ Date(s) of Program:____________________________
Financial Assistance Awarded (%):____________________
Branch Executive Signature:____________________________ Date Approved:____________________
Processor Signature:____________________________ Date:____________________