FOR OFFICE USE ONLY: BC FF M AP **M T W Th F** DSS NEW

Goal After-School

Contact: Kirk - 914-481-7415 | Fax: 914-478-0332
Email: Goalprogram@live.com
Website: www.mygoalprogram.com

APPLICATION

(Please Print)

Child's Last Name: _____ First Name:_____ M.I. ___ DOB _____

Child Teachers Name: _____ Child Grade: ____Age: ____ Gender: M__ F__ School: _____

Mother's Full Name/Guardian_____

Address_____ apt # _____

City _____State_____ Zip _____

Home Phone _____ Cell: _____

Job Location & Address: _____ City _____ State _____

Zip _____ Work Phone: _____ ext _____ Email: _____

Father's Full Name/Guardian_____

Address_____ Apt # _____

City _____ State _____ zip _____

Home Phone: _____ Cell: _____

Job Location & Address: _____ City _____State_____

Zip _____ Work Phone: _____ Ext _____ Email:_____

Emergency Contact List:

Name: _____Phone: _____Cell_____

Name: _____Phone: _____Cell_____

A copy of your child's medical form is needed to complete this application!

After-School Program

We agree to provide After-School programs for your child (ren), during the hours of 2/3:00 pm to 6:00pm, Monday through Friday.

Holiday & School Closings:

After-School Program will follow Yonkers Public School calendar. After-school program will be closed, when school is closed, and closed for half school days as well. Weekly after-school fees will be adjusted for weeks when school is closed for two or more consecutive days per week (due to emergency closings).

Sickness:

If your child becomes sick during After-School programs, a Parent/Guardian will be called immediately. If any child is hurt or severely injured, After-School Program will follow the NYS Office of Children and Family Services guidelines. *Additional information will be provided in the GOAL Program Parent Guide.*

We reserve the right to exclude any child (ren) from attending our After-School Program who is clearly physically aggressive, as well as poses a physical threat to themselves or the safety of the other children in our care.

Yes ___ or No ____I agree for my child's picture to be taken for the After-School bulletin board, flyer, and website.

My child will attend Afterschool at: School 31____ School 17_____ School 29_____ School 32_____ School 22_____ Pearls_____(Note the change in fees for children who attend Pearls, School dismissal is 2:15pm)

After-School Fees - Payment is due every week on Monday or first school day of that week. Registration is a one time fee of $25. Please place payment in a sealed plain envelope labeled Goal Afterschool Fees. Late fee is $15 per 15 minutes after 6pm.

We provide sibling discount please ask After-School Director for further details.

Option 1 - For After-School Programs 4-5 days a week is $105 per week (Children attending Pearls, fee is $120 per week). Please check following days your child will attend. M____ T ____W _____ Th _____ F_____

Option 2 – For After-School Programs 2-3 days per week is $85 per week (Children attending Pearls, fee is $95 per week). Please check following days your child will attend, M _____ T _____W _____ Th _____ F _____

All After-School Fees are non-refundable. All fees are paid using the GOAL Program Automatic Payment Form. Thank you for choosing the Goal Program! Please ask about our Summer Program!

_____ _____

Parent/Guardian Signature **Date**

OCFS-LDSS-0792 (1/2005) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DAY CARE REGISTRATION

PHOTO OF CHILD (Optional)

Child's Full Name:

Does your child have any allergies? ☐ Yes ☐ No

If Yes, what is your child allergic to?

Children who have special health care needs are those who have chronic physical, developmental, behavioral or emotional conditions expected to last 12 months or more and who also require health and related services of a type beyond that required by children generally. If your child does have special health care needs please discuss these with your child-care provider.

Child's Source of Medical Care/Primary Care Physician's Name:	Telephone Number:
Child's Source of Dental Care/Dentist's Name:	Telephone Number:
Name Of Medical Care Facility/Hospital:	Telephone Number:

Would you like information on Child Health Plus? ☐ Yes ☐ No

EMERGENCY DATA

RELATIONSHIP	CONTACT NAME	TELEPHONE NUMBER DURING CHILD CARE	OTHER TELEPHONE NUMBER (Check type)
			☐ Pager ☐ Cell ☐ Other
			☐ Pager ☐ Cell ☐ Other
			☐ Pager ☐ Cell ☐ Other
			☐ Pager ☐ Cell ☐ Other

Provider/Day Care Facility Name and Address:

CHILD'S FULL NAME:

SEX: ☐ Male ☐ Female

CHILD'S HOME ADDRESS:

DATE OF BIRTH:

HOME TELEPHONE NUMBER:

DATE OF ACCEPTANCE:

DATE OF DISCHARGE:

NAME OF PERSON APPLYING FOR CHILD:

☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative ☐ Other _____

HOME TELEPHONE NUMBER:

DAYTIME TELEPHONE NUMBER:

ADDRESS OF PERSON LISTED ABOVE: (IF DIFFERENT FROM CHILD'S):

AGREEMENTS

I consent to the enrollment of the child listed above in this facility and have been advised of the policies regarding administration of medications, fees, transportation and the services provided by the facility, and the Office of Children and Family Services regulations under which it operates.

I give consent for my child to take part in neighborhood trips (i.e. library, park and playground) away from the facility under proper supervision. ☐ Yes ☐ No

In case of accident or injury, I authorize any and all emergency medical, dental, and /or surgical care and hospitalization advised by the physicians, surgeon or hospital (listed on the other side of this card) necessary for the proper health and well-being of my child. ☐ Yes ☐ No

I have provided information on my child's special needs (Allergies, Diet, Disabilities, and /or Medical Information) to the provider, as may be necessary to assist the facility in properly caring for my child in case of an emergency. ☐ Yes ☐ No

I agree to review and update this information whenever a change occurs and at least once every six months. ☐ Yes ☐ No

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE

DATE:

CACFP
Child and Adult Care Food Program
New York State Department of Health

INCOME ELIGIBILITY FORM
for Child Care Centers

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME: _____

Print the name of the child(ren) enrolled in this child care center:

1. _____ 2. _____ 3. _____

DIRECTIONS:

Complete SECTION A if anyone in your household:

1. Receives Food Stamps
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR) OR
4. If any of the children enrolled in this child care center are foster children

Complete SECTION B if no one in your household receives Food Stamps, TANF, FDPIR or if none of the children enrolled in the child care center is a foster child.

SECTION A

Food Stamp Case Number _____

TANF Number _____

FDPIR Number _____

Names of Foster Children _____

_____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true. I understand that the center will get Federal funds based on the information I give.

Signature: _____

Date: _____

FOR SPONSOR USE ONLY

Sponsor Agreement Number _____

Total Household Members _____
(including foster children, if applicable)

Total Income $_____

Free _____ Reduced _____ Paid _____

Date Determined _____ / _____ / _____

Signature of Center Staff _____

SECTION B

List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received **last month** in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, child support, foster child's personal income and any other sources of income.

Name of Household Members	Monthly Gross Income
1. _____	$ _____
2. _____	$ _____
3. _____	$ _____
4. _____	$ _____
5. _____	$ _____
6. _____	$ _____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true and that all income is reported. I understand that the center will get Federal funds based on the information I give.

Signature: _____

Print Name: _____

SS# XXX-XX-_____ Date: _____

OCFS 6013 (2/2015)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

TRANSPORTATION CONSENT FORM

Child Day Care Programs

Provider Name: The GOAL Program Facility ID Number: 647852, 647843, 647854

Program Name: The GOAL Program Facility ID Number: 694717, 630587 & 663565

This form may be used to meet the regulatory requirement to obtain written consent from the parent of a child for any transportation provided or arranged for by a caregiver, and to inform the parent when the person who is providing transportation changes. This form is not the Transportation Plan.

Parents whose children receive transportation services must receive, at the time of enrollment of their children, a copy of the program's transportation plan. If the plan is amended, parents must receive a copy of the amended plan prior to its start date.

It is recommended that a separate Transportation Consent Form be completed for each child.

☐ I have been informed of, and agree to, the transportation plan of the above child care program.

Transportation Plan is attached to this Transportation Consent Form (Yes / No) *circle one*

Date of Transportation Plan _____

☐ I give permission for my child *(name)* _____

to be transported by *(caregiver names and/or transportation contractor arranged for by the program)* _____

Parent Cell#:

Parent Work#:

At the following times *(check all that apply)*:

☐ Only as recorded on the posted transportation schedule for my child

☐ Other *(explain)*

_____

_____

_____

By signing this form I am giving consent for the above described transportation services.

Parent Printed Name: _____

Parent Signature: **X** _____

Date _____

SUMMERS PROGRAM PARTICIPAMTS ONLY!