**Trinity Day Care**
215 N. 1st Street
Rockford, IL 61107
815-986-KIDS(5437)
Fax: 815-986-2275
info@trinitydaycare.com
www.TrinityDayCare.com


# Contents

- Enrollment Form
- Emergency Medical Release Form
- Social Sheet
- Consent to Use Name and/or Photos
- Screenings Consent
- State of Illinois Certificate of Child Health Examination
- Trinity Day Care Payment Policies
- ACH Service Agreement

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*"Working Together to Provide a Secure, Nurturing, Educational Environment for Children and Families."*

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## Packet Contents

- Enrollment Form
- Emergency Medical Release Form
- Social Sheet
- Consent to Use Name and/or Photos
- Screenings Consent
- State of Illinois Certificate of Child Health Examination (physical form)
- Trinity Day Care Payment Policies
- ACH Service Agreement
- Illinois State Board of Education - Child and Adult Care Food Program (CACFP)
- Child Care Assistance Program (CCAP) Application, if applicable (please allow 10 business day for processing)
    a. Completed application, parent/guardian verification of employment and/or school schedule

## The following must be received 1 business day prior to start date.

**Please check off to make sure you have all required documentation:**

- ☐ Completed enrollment packet
- ☐ Child's birth certificate
- ☐ Child's current physical (including immunizations and lead screening)
- ☐ Payment
- ☐ Work Letters / School Schedule (must include hours)
- ☐ Copy of approval letter for parents participating in the Child Care Assistance Program (CCAP)
- ☐ Additional for foster parents
    - ☐ Completed DCFS childcare payment application
    - ☐ Copy of custody arrangements and visitation schedule

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**Office Use Only**

Expected Start Date: _____

Classroom Number: _____

# Enrollment Form

**Child Name: _____ Age: _____ Birth Date: _____ Male/Female**

***Please circle and/or fill in all of the applicable enrollment information below.***

**Enrollment Type**: Infant Toddler Preschool Preschool (ABeka) School Age

**Days Attending:** Monday Tuesday Wednesday Thursday Friday

**Average Daily Drop-Off Time: _____ Average Daily Pick -Up Time: _____**

---

**School Age Specific Information**

**My child will attend:** before school, after school, no school days, during school year breaks, summer camp

**Elementary School Name: _____ Grade Level: _____**

**Bus route number to school: _____ Before school bus pick-up time: _____**

**Bus route number from school: _____ After school bus drop-off time: _____**

---

**Please list any other pertinent transportation, arrival/departure, enrollment schedule information here:**

---

**The following must be turned in 24hrs <u>before</u> start date:**

- Completed enrollment packet
- Child's birth certificate
- Child's current physical (including immunizations and lead screening)
- Payment
- Additional for parents participating in the Child Care Assistance Program
    - Completed CCAP application
    - Parent/guardian verification of employment and/or school schedule
- Additional for foster parents
    - Completed DCFS childcare payment application
    - Copy of custody arrangements and visitation schedule

**Parent Name: _____ Signature: _____ Date: _____**

*Additional Enrolling Parent/Guardian Information (optional):*

**Parent Name: _____ Signature: _____ Date: _____**

# Behavior Guidelines Policy

**Objective:**
To provide a secure, nurturing, and educational environment for children, families and staff. Avoid or eliminate unsafe, inappropriate or disruptive behavior practices elicited by a child.

**Scope:**
Inappropriate or unsafe behaviors include (but are not limited to): hitting, biting, kicking, pinching, willful and inappropriate urination or defecating, inappropriate sexual aggression toward other children, throwing furniture, tipping furniture over, aggression toward staff, spitting, running out of the classroom, throwing/spitting food, eating food off of other children's plates, *harming the physical environment*, refusing to cooperate with redirection, and/or *any other behavior that is detrimental to the individual child or the group.*

**Responsibility:**
S*taff members are responsible for facilitating Trinity Day Care's "A Positive Approach to Discipline" policy and the following guidelines to achieve the objective.* The staff member in charge of a child at the time of an occurrence is specifically responsible for completing a behavioral report. A copy of the behavioral report shall be given to the parent/guardian. *Parents are responsible to act in partnership with staff to promote our objective and the success of the child(ren).*

**Behavioral Guidelines:**

1. The child will be redirected from the above mentioned behavior in the classroom. The child may be redirected to a different activity or the problem solving area. The problem solving/quiet area is a quiet place in the classroom where the child can reflect on different ways to handle the situation at hand.
2. If unsuccessful, the child may be visited by *support* personnel to provide further assistance to help the child resume displaying appropriate behavior. The parent may be notified by an office personnel or the child's teacher at this point.
3. If the child's inappropriate behavior continues and he/she is not able to be successful in his/her classroom, the parent will be required to pick up the child immediately.
4. If the child's inappropriate behavior is ongoing, a meeting will be set up to discuss the issues and create a plan to support the child's success. This plan may be revisited to assess the child's progress and/or if it is deemed unsuccessful. Behavior plans may need to be revised several times before finding the most successful strategy for an individual child and require parent participation.
5. After these attempts have been made to meet the child's individual needs and the child continues to demonstrate inability to benefit from the type of care offered at Trinity Day Care, or whose presence is detrimental to the group, the child shall be discharged from the day care. In the event of discharge the center will provide referrals to other agencies *and support a successful caregiving transition.*

**I understand and agree to the guidelines of this policy for my child, _____,**
**and the expectation of my support and participation to his/her success.** *child's name*

**Parent Signature: _____ Date: _____**

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# Emergency Medical Release Form

Child Name _____ Birthdate _____/_____/_____
Last First Middle Month Day Year

Address_____ Phone _____
Number and Street City Zip

The child is male ___ female ___ and lives with Mother ___ Father ___ Guardian _____
Please specify relationship if guardian.

**Mother**/Guardian Name _____ Cell # _____ Work # _____

Birthdate _____/_____/_____ Place of Employment _____ Email Address _____

**Father**/Guardian Name _____ Cell # _____ Work # _____

Birthdate _____/_____/_____ Place of Employment _____ Email Address _____

**Emergency Contacts and Pick-up List**: List at least two individuals authorized to pick-up your child that we can call if you are unable to be reached in case of an emergency.

Contact Name _____ Relationship _____ Phone # _____

Contact Name _____ Relationship _____ Phone # _____

Contact Name _____ Relationship _____ Phone # _____

Contact Name _____ Relationship _____ Phone # _____

Contact Name _____ Relationship _____ Phone # _____

Contact Name _____ Relationship _____ Phone # _____

Additional contact or pick up instructions/information: _____

_____

_____

Child's Doctor _____ Preferred Hospital_____

Special health/allergy considerations apply for my child: ☐ YES ☐ NO If yes, provide additional information.

I do hereby authorize Trinity Day Care to contact directly the persons named on this form, and do authorize the named physician or his associates to render such treatments as may be deemed necessary in an emergency, for the health of the said child. Trinity Day Care is further authorized to take whatever action is deemed necessary in the judgement for the health of foresaid child. I have read and agree to the above statement as it is written.

Parent Signature Date Parent Signature Date

Revised 6/2022

**Trinity Day Care**

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I (We), _____, the parent(s) of _____
print parent's name(s) above print child's name above

hereby certify that I (we) have received, understand and agree to comply with the following.

## Verification of Receipt:

- Trinity Day Care/TDC School Age Program Parent Handbook
- Parent Communication Flyer
- Behavior Guidelines Policy
- Child Care Food Program Brochure (CACFP)
- Food Policy
- Screening and Assessment
- Photo Release
- DCFS Licensing Standards Summary
- Payment Policy

Parent Signature Date Parent Signature Date

## Permission Agreement:

→ I give permission for my child(ren) _____ to leave the center with qualified daycare staff and participate in daily walks/visits to nearby parks, special events, faith based programming, and fieldtrips.

→ I understand that Trinity Day Care will share information about my child with DCFS as required by licensing.

→ I agree to act in support of Trinity Day Care's mission, working together "to provide a secure, nurturing, educational environment for children and families."

→ I understand that my child's attendance is required to be at least 80% of the days enrolled on a monthly basis.

→ In consideration of the participation in Trinity Day Care and/or TDC School Age programs and the use of Trinity Day Care's premises and facilities by the minor(s) named above, I hereby agree to release and indemnify Trinity Day Care, its officers and directors, agents, landlords, affiliated companies or organizations, and employees from any and all claims for property damage or loss, injury, or death which the minor(s) may suffer in any way connected with the Trinity Day Care program, including travel to and from the day care and/or its activities. I accept full responsibility for all medical expenses incurred as a result of the minor's participation in Trinity Day Care's day care programs and his/her use of Trinity Day Care's premises and facilities, and I agree to indemnify and hold harmless Trinity Day Care from any claim brought by or on behalf of the minor. This release and indemnity agreement is applicable to any claim based upon negligence and any other theory of recovery, except claims based upon willful or intentional misconduct. I further agree to release and indemnify Trinity Day Care and all other individuals and entities noted above from any and all liability which might result from an act or omission by the minor(s) named above. I also agree that all disputes between myself or the minor(s) named above and Trinity Day Care arising from my/our use of Trinity Day Care's facilities or services will be governed by the laws of the State of Illinois and the exclusive jurisdiction therof shall be in the state courts of the State of Illinois, and the venue for these disputes shall be in Winnebago County, Illinois. If any part of this contract is determined to be unenforceable for any reason or in any circumstance, it is intended that all other terms will be enforceable.

→ I HAVE CAREFULLY READ THIS RELEASE AGREEMENT, ALL OF ITS TERMS AND UNDERSTAND IT.

→ I verify that I am the parent/guardian of the above listed minor(s). I agree to be bound by the terms of this agreement.

Parent Signature Date Parent Signature Date

**Trinity Day Care**

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**Office Use Only**

Expected Start Date: _____

Classroom Number: _____

# Social Sheet

**Child Name: _____ Nick Name: _____**

**Mother**/Guardian Name: _____ Lives with Mother YES ☐ NO ☐

**Father**/Guardian Name: _____ Lives with Father YES ☐ NO ☐

## Custody and Visitation Arrangements:

Provide details such as visitation schedules (or lack thereof), special/temporary living arrangements, custody changes, other major life changes, etc. that may be helpful to us in understanding your child and providing him/her with nurturing care.

_____

Who else lives in the home with the child and what are their ages?_____

_____

*Circle all that apply below.*

**Previous caregiving experiences:** None Close friend/relative One on one

Small group care (less than 10 children) Daycare home Daycare center Other_____

What challenges and/or successes has your child experienced with other caregiving or social situations with other children?

_____

## When does your child experience regular routines and behavior expectations at home?

Breakfast Lunch Snack Dinner Nap Bedtime Playtime/pick-up Reading time

Bathing procedures Trips/visits All the time Most of the time Other _____

## What type of discipline do you use at home?

Praise/Positive Reprimand Time Out Loss of Privileges Physical Discipline Logical Consequences

Strict Permissive Set clear expectations Loving/affectionate Encourage use of language

Further explanation about discipline that may be helpful for us in working with your child:_____

_____

Do you feel successful with the discipline techniques you are using? ☐ YES ☐ NO

Who are the primary disciplinarians? _____

_____ Do their styles match? ☐ YES ☐ NO

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**Does your child have any known allergies or asthma?** ☐ YES ☐ NO

If yes, please see the office for allergy form ISBE 67-44, which is required in order for us to provide special accommodations.

Please describe allergy and accommodations needed:_____

**Does your child receive any special services or have any special needs?** ☐ YES ☐ NO

If yes, please describe._____

**Does your child nap?** ☐ YES ☐ NO

If yes, please describe the routine and normal length of nap_____

_____

**Does your child have a "fussy" time or certain triggers that we should be aware of?**

_____

**Is your child fully potty trained?** ☐ YES ☐ NO If NO, circle the items that apply for your child below.

Not ready Started potty training Has occasional accidents Needs bathroom reminders Indicates bathroom needs

Needs a diaper at nap only Other applicable information: _____

**Please summarize your child's likes, dislikes, fears, abilities, temperament, play habits, etc.**

_____

_____

**What do you want your child to gain from his/her experience while attending?**

_____

**Infant/Toddler/Special Needs Feeding and Eating Information** (Circle all that apply.)

**Feeding Schedule:** every ____ hours five times a day four times a day three times a day

***If breast milk or formula feeding, please specify how many ounces per feeding:*** _____ Other: _____

**Feeding Style:** On an adult's lap/held In a high chair/booster Independently Spoon/hand fed

Additional Information: _____ **Eats with:** hands utensils both

**Drinks from:** warm bottle room temp bottle cold bottle breast fed cup with a lid cup with no lid

**Food/Drink Type/Tendencies:** Eats Baby Food Eats Table Food Drinks Breast Milk

Drinks Formula Drinks Whole Milk Drinks Cow's Milk Drinks juice Drinks Water

Picky Eater Very good eater-asks for more Eats most of his/her food

# Consent to Use Name and/or Photos

The use of children's pictures in Trinity Day Care's educational efforts, marketing and social media activities is valuable for many reasons. We all know people are visual and the use of children's pictures promotes interest in our center, which facilitates relationship building. Developing positive, meaningful, long lasting relationships is critical for Trinity Day Care's long term success, which is why we are asking for your help.

I, _____, hereby give **Trinity Day Care, Inc.** the absolute right, until revoked in writing, to use my child's name, quotes and/or photos and images on the Internet (World Wide Web), in print publications, video and multimedia presentations, and/or for any purpose which may include, but not limited to display, public relations, marketing, or designs. I understand that my child's name and/or the images may be used for display or advertisement for the web site and/or literature published. I hereby waive the right to inspect or approve the images prior to any form of usage. I understand that the images may be modified to be used as design elements.

This agreement allows Trinity Day Care, Inc. to use any images, quotes and/or my child's name for any publishing purposes in the promotion of Trinity Day Care, Inc. and its nominees. I will not hold Trinity Day Care, Inc. responsible for any use or misuse of my name, quotes and/or the images. I agree to hold harmless Trinity Day Care, Inc., its agents or successors in interests from any and all actions, claims, and demands a rising out of or in connection with the use of all or any part of the photographs (including computer images or reproductions of any kind), including any editorial or comment which may accompany the images in their displayed format and/or my name. I will not hold Trinity Day Care, Inc., its agents or successors in interest, liable for any errors/negligence in the editing or displaying of said images, quotes and/or in the use of my child's name.

By signing this agreement, or by signing this agreement on behalf of a minor in the state of Illinois, I am giving Trinity Day Care, Inc. the right to use my child's name and own the images and use them for any purposes without further approval from me. I am releasing all rights to any images. Should I revoke this consent in the future, I understand that the revocation does not apply retroactively, and that any images previously used with prior consent in publications, advertisements, or promotions, will remain unchanged and in use at the discretion of the directors and managers of Trinity Day Care, Inc.

Child/Minor Name _____ Date of Birth _____

Parent/Legal Guardian Name _____

Parent/Guardian Signature _____ Today's Date _____

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# Ages & Stages Questionnaires (ASQ-3/ASQ-SE) – Notice and Consent

It is important that we work to ensure each child's development is proceeding without problems during these crucial early years. Developmental screening is a way for us to accomplish this and assist you in monitoring your child's growth and development.

Trinity Day Care will conduct developmental screening for your child, between the ages of six weeks and five years old before entering kindergarten using the Ages and Stages Questionnaires (ASQ-3 and ASQ-SE). Screenings are conducted within the first few months of enrollment and approximately every four months thereafter until early preschool (2 1/2 years old), where they will be screened yearly until kindergarten. Parents are given copies of the teacher completed assessment questionnaires and are encouraged to discuss results with the teachers. Parents may also request a blank Ages and Stages Questionnaire of their own to complete, which is the ideal situation. Then, parents and teachers can share and compare information about the screening in the best interest of the child.

Most of the time, children will score in the normal or higher range of development for their age. There will be sometimes when a child is not in the normal range of development. When this happens, we need to take prompt action in the best interest of the child. If a child's development is significantly below the normal range, a referral is required. By law, our professionals have seven days to report a significant delay to a referral agency (i.e. Child and Family Connections). Teachers are required to refer a child through their professional observation or by sending in the Ages and Stages Questionnaire. We hope our screening process helps you to better understand your child's developmental milestones and builds stronger parent-teacher relationships to promote the success of your child.

## Acknowledgement and Statement of Consent

I have read and understand the developmental screening process noted above. I understand the purpose and intent of the screening. Please check the box that applies that to your position in regards to consent

☐ ***I give my informed consent*** for Trinity Day Care to carry out the described developmental screening process for my child.

☐ ***I do not give my consent*** for the developmental screening to be administered for my child and I do not wish to participate in the screening process. There will be no future claims made against Early Care and Education Practitioners, the Early Intervention Services System, or the local public school system.

_____

Parent/Guardian Signature Date

## Consent for Release of Information

I further understand that Part C of individuals with Disabilities Education Act (IDEA) mandates that childcare providers refer the identification of a possible delay to Child and Family Connections (CFC) within seven days of recognition of a delay. Please check the box that applies that to your position in regards to consent for release of information.

☐ ***I, therefore, consent to the release of the ASQ-3/ASQ-SE or any other necessary information pertaining to my child's development by Trinity Day Care*** to CFC about my child in the event it is identified that my child may have a developmental delay or disability in order to seek appropriate early intervention support services.

☐ ***I do not consent to the release of my child's ASQ-3/ASQ-SE screening results or related information*** to the CFC, but understand my child's teachers are still required, by law, to make a verbal referral to CFC and that someone may contact me about the teacher's developmental concerns. There will be no future claims made against Early Care and Education Practitioners, the Early Intervention Services System, or the local public school system.

_____

Parent/Guardian Signature Date

# PARENT LETTER
# FOR CHILD CARE CENTERS
July 1, 2022 Through June 30, 2023

Parent or Guardian:

This child care center participates in the USDA Child and Adult Care Food Program (CACFP) and receives Federal funds to provide healthy meals and snacks to all of the enrolled children. The amount of reimbursement the center receives is based on the information you provide on the attached Household Eligibility Application. Part of the USDA requirement is to ask you to complete the application. If your income is equal to or less than the income listed in the chart below for your household size, the center will receive a higher level of reimbursement. Read the attached instructions carefully and fill out all required information. We cannot approve an application that is not complete. Please return the completed application back to our center as soon as possible.

If a member of your family (child or adult) receives Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) benefits; or you care for a foster child that is the legal responsibility of the State through DCFS or the court, these children are eligible for meal benefits regardless of your household income.

If your income(s) is over the income guidelines listed below, you are not required to complete this application; however, it would be helpful if you would write your child's name on the application and return it to our center. Please notify us, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the income eligibility standards.

**Income Eligibility Guidelines**
**Effective from July 1, 2022 to June 30, 2023**

**Reduced-Price Meals**
**185% Federal Poverty Guideline**

| Household Size | Annual | Monthly | Twice Per Month | Every Two Weeks | Weekly |
|---|---|---|---|---|---|
| 1 | 25,142 | 2,096 | 1,048 | 967 | 484 |
| 2 | 33,874 | 2,823 | 1,412 | 1,303 | 652 |
| 3 | 42,606 | 3,551 | 1,776 | 1,639 | 820 |
| 4 | 51,338 | 4,279 | 2,140 | 1,975 | 988 |
| 5 | 60,070 | 5,006 | 2,503 | 2,311 | 1,156 |
| 6 | 68,802 | 5,734 | 2,867 | 2,647 | 1,324 |
| 7 | 77,534 | 6,462 | 3,231 | 2,983 | 1,492 |
| 8 | 86,266 | 7,189 | 3,595 | 3,318 | 1,659 |
| For each additional family member, add | 8,732 | 728 | 364 | 336 | 168 |

The information you provide on the application will be used to determine your child's eligibility for meal benefits. The information will be kept confidential and only available to staff directly connected with administering the CACFP.

By signing the section on the application for the Illinois All Kids Health Insurance, you are stating you do not want your information shared with the Illinois Department of Healthcare and Family Services. If you agree to disclose the application information, it may be used to identify your child(ren) for the health insurance program. If you would like more information on All Kids, call toll-free (866) 255-5437 or (877) 204-1012 (TTY).

If you have any questions or need help, please contact our center.

The USDA Household Income Eligibility Guidelines are listed for families who do not receive TANF or SNAP benefits. If a household's income falls within or below the listed guidelines, they should contact their child care center or day care home provider for the benefits of the program. They may be required to complete an application and provide income, TANF, or SNAP information.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider. (10/15)

## INSTRUCTIONS FOR APPLYING - COMPLETE ONE APPLICATION PER HOUSEHOLD

Follow These Instructions and Return the Completed form to your Center. Once approved for meal benefits, a child's Household Eligibility Application is effective for 12 months.

### FOSTER CHILD(REN)

A foster child remains the legal responsibility of the state through a foster care agency or the court. If you submit documentation from the state or local agency that the child is in foster care, that documentation replaces completing a Household Eligibility Application.

1) If all children in your household (who attend this center) are foster children that are the legal responsibility of a foster care agency or court, provide the following:
   - Part 1 — List the name(s) and age(s) of your foster child(ren) attending this center.
   - Part 2 — Check the box(es) indicating a foster child(ren).
   - Part 3 — 5 Skip
   - Part 6 — Provide a signature of an adult household member and date the application.
   - Parts 7-9 — (OPTIONAL)

2) If you have some foster children that are the legal responsibility of a foster care agency or court along with other children attending this center, please provide the following:
   - Part 1 — List ALL household members, including the foster child(ren), and the age(s) of the child(ren) attending the center.
   - Part 2 — Check the box(es) identifying the foster child(ren).
   - Part 3 — Record a valid SNAP/TANF case number if applicable
   - Part 4 — Skip
   - Complete Parts 5 and 6 if applicable. See the instructions for **INCOME–HOUSEHOLDS REPORTING** section.
   - Parts 7-9 — (OPTIONAL)

### SNAP OR TANF BENEFITS - HOUSEHOLDS RECEIVING

If any member (child or adult) of your household receives SNAP or TANF benefits, provide the following:
- Part 1 — List ALL people in your household (including grandparents, other relatives, or friends who live with you) and the age(s) of the child(ren) attending the center.
- Part 2 — Skip
- Part 3 — Record a valid SNAP or TANF case number for any member (child or adult) of this household. You will find your SNAP or TANF case number on your letter of eligibility for benefits.
- Part 4 — 5 Skip
- Part 6 — Provide a signature of an adult household member and date the application.
- Parts 7-9 — (OPTIONAL)

### HOMELESS, MIGRANT, RUNAWAY, OR HEAD START

If no one in your household receives SNAP or TANF benefits and if any child is homeless, a migrant, a runaway, or head start, follow these instructions.
- Part 1 — List ALL household members, and the age(s) of the child(ren) attending the center.
- Part 2 — 3 Skip
- Part 4 — If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call your local school.
- Part 5 — Complete only if a child in your household isn't eligible under Part 4. See instructions for **INCOME – HOUSEHOLDS REPORTING** section below and complete Parts 5 and 6.
- Part 6 — Provide a signature of an adult household member and date the application.
- Parts 7-9 — (OPTIONAL)

### INCOME - HOUSEHOLDS REPORTING

If no one in your household receives SNAP or TANF benefits, please report all household income. The Household Eligibility Application must include the following information:
- Part 1 — List the names of ALL household members and the age(s) of the child(ren) attending the child care center.
- Part 2 — 4 Skip
- Part 5 — List total gross income (before deductions), not take-home pay; and the frequency, how often the money is received, for each household member for last month. If the income last month was not the usual amount you normally receive, you may provide a projected amount that better represents your gross income.
  - For ONLY the self-employed, list income after expenses. This is for your business, farm, or rental property.
  - If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.
  - If you have no income, list zero in the earnings from work column.
- Part 6 — Provide a signature of an adult household member and date the application. Also, provide the last four digits of the Social Security Number for the adult signing the application. If you refuse to provide the last four digits of the social security number, the application cannot be approved. If the adult does not have a Social Security Number, mark the box, I do not have a Social Security Number.
- Parts 7-9 — (OPTIONAL)

### PRIVACY AND DISCRIMINATION STATEMENT

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced-price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program, or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced-price meals, and for administration and enforcement of the Child and Adult Care Food Program. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

# ILLINOIS STATE BOARD OF EDUCATION
## Annual Enrollment Form
### Child and Adult Care Food Program

**This form is required for Child Care Centers, Pre-K, Head Start, Even Start, and Licensed Outside School Hours Programs.**

**This form is NOT required for At-Risk After-School, License-exempt Outside School Hours, or Emergency Shelters.**

**Parents/Centers:** This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents or guardians to complete or review a CACFP Annual Enrollment Form when enrolling their child(ren) and every year thereafter.This information will help ensure all children receive appropriate meals during their care. The parent or center may complete Sections 1 through 4. The parent must review to ensure accuracy; then complete Section 5, sign and date Section 6. Section 5: this section is optional. CACFP sponsors must ensure households are made aware that failure to provide racial or ethnic identity information will not impact their eligibility. However USDA strongly encourages CACFP sponsors to explain the importance of this data to parents/guardians to complete this section. The center will review completed enrollment form.

**1** FULL NAME OF ENROLLED CHILD (Include Birth Date/Age) | **2** DAYS OF WEEK IN ATTENDANCE | **3** TIMES CHILD NORMALLY ATTENDS DURING WEEK | **4** MEALS RECEIVED

**First Child**

Name

Birth Date

Age

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

| TIME IN | | | TIME OUT | | | TIMES CHILD ATTENDS SCHOOL | |
|---|---|---|---|---|---|---|---|
| AM | PM | TIME | AM | PM | TIME | Leaves Center | Returns To Center |
| | | | | | | | |

☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours

☐ Breakfast ☐ Lunch ☐ P.M. Snack

**Second Child**

☐ Same Days as Above ☐ Same Times as Child Above ☐ Same Meals as Above

Name

Birth Date

Age

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

| TIME IN | | | TIME OUT | | | TIMES CHILD ATTENDS SCHOOL | |
|---|---|---|---|---|---|---|---|
| AM | PM | TIME | AM | PM | TIME | Leaves Center | Returns To Center |
| | | | | | | | |

☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours

☐ Breakfast ☐ Lunch ☐ P.M. Snack

**Third Child**

☐ Same Days as Above ☐ Same Times as Child Above ☐ Same Meals as Above

Name

Birth Date

Age

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

| TIME IN | | | TIME OUT | | | TIMES CHILD ATTENDS SCHOOL | |
|---|---|---|---|---|---|---|---|
| AM | PM | TIME | AM | PM | TIME | Leaves Center | Returns To Center |
| | | | | | | | |

☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours

☐ Breakfast ☐ Lunch ☐ P.M. Snack

***Please answer both questions. This information is voluntary.***

**5** **ETHNIC/RACIAL CATEGORIES—**

A. Ethnic data of child(ren) — Mark only one. ☐ Hispanic or Latino ☐ Not Hispanic or Latino

B. Racial data of child(ren) — Mark one or more that apply. ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ American Indian or Alaska Native

**6** **SIGNATURE**

I certify the information above is correct. _____ *Signature of Parent or Guardian* _____ *Date* _____ *Telephone Number of Parent or Guardian*

**CHILD CARE REPRESENTATIVE USE ONLY**

Effective Date of this enrollment form: _____

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

The U.S Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer

## HOUSEHOLD ELIGIBILITY APPLICATION FOR CHILD CARE CENTERS
## CHILD AND ADULT CARE FOOD PROGRAM

| 1. All Household Members | | 2. | 3. |
|---|---|---|---|
| **NAMES OF ALL HOUSEHOLD MEMBERS** First, Middle Initial, Last | Ages of Children at Center | **FOSTER CHILD** Foster children are a legal responsibility of DCFS or court. If all are foster children, skip to Section 6 | **SNAP OR TANF CASE NUMBER** Skip to Part 6 if you list a SNAP or TANF case number. At least one SNAP/TANF must be provided below. |
| | | ☐ | |
| | | ☐ | |
| | | ☐ | |
| | | ☐ | |
| | | ☐ | |
| | | ☐ | |

**4. Homeless, Migrant, or Runaway**

☐ Homeless ☐ Migrant ☐ Runaway ☐ Head Start

Signature of Homeless Liason, Migrant Coordinator, or Head Start Director _____ Date _____

**5. Total Household Gross Income (before deductions) You must tell us how much and how often.**

| NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME) | GROSS INCOME AND HOW OFTEN IT WAS RECEIVED (Example: $100/month; $100 /twice a month; $100/every other week; $100/week) | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Earnings From Work (Before Deductions) | | Welfare, Child Support, Alimony | | Pensions, Retirement, Social Security | | Worker's Comp., Unemployment, SSI, etc. (All other income) | |
| | Amount | How often? | Amount | How often? | Amount | How often? | Amount | How often? |
| i. | $ | | $ | | $ | | $ | |
| ii. | $ | | $ | | $ | | $ | |
| iii. | $ | | $ | | $ | | $ | |
| iv. | $ | | $ | | $ | | $ | |
| v. | $ | | $ | | $ | | $ | |

**6. Signature and Social Security Number (Adult must sign)**

An adult household member must sign the application. If Section 5 is completed or if zero income is listed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "*I do not have a Social Security Number*" box.

X X X - X X - _ _ _ _ Social Security Number

☐ I **do not** have a Social Security Number.

*I certify all information on this application is true and all income is reported. I understand the center will get federal funds based on the information I give. I understand the institution, Illinois State Board of Education, or Office of Inspector General, may verify this information on the application. Deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.*

*Date* _____ *Printed Name of Adult Household Member* _____ *Signature of Adult Household Member* _____

**7. Contact Information (Optional)**

*Work Telephone Number (Include Area Code)* _____ *Home Telephone Number (Include Area Code)* _____ *Home Address (Number, Street. City, State. ZIP Code)* _____

**8. Children's Racial and Ethnic Identities (Optional)**

Mark one ethnic identity:
☐ Hispanic/Latino
☐ Not Hispanic/Latino

Mark one or more racial identities:
☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ White ☐ American Indian or Alaska Native

**9. Optional – Sharing Information With All Kids Insurance Program**

May we share your information on this application with the *All Kids Insurance Program*, the complete health insurance program for every child in Illinois? If **yes**, do not sign below.
☐ No, I do not want my information from this application shared with the *All Kids Insurance Program*.

Date: _____ Sign here: _____

### CHILD CARE REPRESENTATIVE USE ONLY
***Eligibility Determination - Complete Sections A and B Below***

**SECTION A** **Annual Income Conversion Weekly X 52 Every 2 Weeks X 26 Twice a Month X 24 Once a Month X 12** ***Convert income only if different frequencies of pay are reported.***

**TOTAL INCOME $** _____ **Per:** ☐ Week ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year **NUMBER IN HOUSEHOLD:** _____

☐ **Free based on:**
- ☐ foster child
- ☐ SNAP or TANF
- ☐ homeless
- ☐ migrant
- ☐ runaway
- ☐ household's income
- ☐ Head Start

☐ **Reduced based on:**
- ☐ household's income

☐ **Denied — Reason:**
- ☐ income too high
- ☐ incomplete application
- ☐ Non-qualifying SNAP/TANF

**SECTION B** **Signature of Determining Official:** _____ **Date:** _____

# State of Illinois
# Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 11/2013

Illinois Department of DCFS Children & Family Services

| Student's Name (Last First Middle) | Birth Date (Month/Day/Year) | Sex | Race/Ethnicity | School /Grade Level/ID# |
|---|---|---|---|---|
| | | | | |

Address (Street City Zip Code) | Parent/Guardian | Telephone # Home | Work

**IMMUNIZATIONS**: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

| Vaccine / Dose | 1 MO DA YR | 2 MO DA YR | 3 MO DA YR | 4 MO DA YR | 5 MO DA YR | 6 MO DA YR |
|---|---|---|---|---|---|---|
| **DTP** or **DTaP** | | | | | | |
| **Tdap**; **Td** or Pediatric **DT** (Check specific type) | ☐Tdap☐Td☐DT | ☐Tdap☐Td☐DT | ☐Tdap☐Td☐DT | ☐Tdap☐Td☐DT | ☐Tdap☐Td☐DT | ☐Tdap☐Td☐DT |
| **Polio** (Check specific type) | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV |
| **Hib** Haemophilus influenza type b | | | | | | |
| **Hepatitis B** (HB) | | | | | | |
| **Varicella** (Chickenpox) | | | | COMMENTS: | | |
| **MMR** Combined Measles Mumps. Rubella | | | | | | |
| **Single Antigen** Vaccines | **Measles** | **Rubella** | **Mumps** | | | |
| **Pneumococcal Conjugate** | | | | | | |
| **Other**/Specify Meningococcal, Hepatitis A, HPV, Influenza | | | | | | |

**Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.** If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

**Signature** **Title** **Date**

**Signature** **Title** **Date**

## ALTERNATIVE PROOF OF IMMUNITY

**1. Clinical diagnosis is acceptable if verified by physician.** *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

**2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.**
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

**Date of Disease** **Signature** **Title** **Date**

**3. Laboratory confirmation (check one)** ☐**Measles** ☐**Mumps** ☐**Rubella** ☐**Hepatitis B** ☐**Varicella**
**Lab Results** **Date** MO DA YR **(Attach copy of lab result)**

## VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

| | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Date** | | | | | | | | | | | | | | | | | | | | | |
| **Age/ Grade** | | | | | | | | | | | | | | | | | | | | | |
| | R | L | R | L | R | L | R | L | R | L | R | L | R | L | R | L | R | L | R | L | |
| **Vision** | | | | | | | | | | | | | | | | | | | | | |
| **Hearing** | | | | | | | | | | | | | | | | | | | | | |

**Code:**
**P = Pass**
**F = Fail**
**U = Unable to test**
**R = Referred**
**G/C = Glasses/Contacts**

| Student's Name (Last / First / Middle) | Birth Date (Month/Day/ Year) | Sex | School | Grade Level/ ID # |
|---|---|---|---|---|
| | | | | |

**HEALTH HISTORY** **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

| **ALLERGIES** (Food, drug, insect, other) | | | | **MEDICATION** (List all prescribed or taken on a regular basis.) | | | |
|---|---|---|---|---|---|---|---|
| Diagnosis of asthma?<br>Child wakes during the night | Yes<br>Yes | No<br>No | | Loss of function of one of paired organs? (eye/ear/kidney/testicle) | Yes | No | |
| Birth defects? | Yes | No | | Hospitalizations?<br>When? What for? | Yes | No | |
| Developmental delay? | Yes | No | | | | | |
| Blood disorders? Hemophilia, Sickle Cell, Other? Explain. | Yes | No | | Surgery? (List all.)<br>When? What for? | Yes | No | |
| Diabetes? | Yes | No | | Serious injury or illness? | Yes | No | |
| Head injury/Concussion/Passed out? | Yes | No | | TB skin test positive (past/present)? | Yes* | No | *If yes, refer to local health department. |
| Seizures? What are they like? | Yes | No | | TB disease (past or present)? | Yes* | No | |
| Heart problem/Shortness of breath? | Yes | No | | Tobacco use (type, frequency)? | Yes | No | |
| Heart murmur/High blood pressure? | Yes | No | | Alcohol/Drug use? | Yes | No | |
| Dizziness or chest pain with exercise? | Yes | No | | Family history of sudden death before age 50? (Cause?) | Yes | No | |
| Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____<br>Other concerns? (crossed eye, drooping lids, squinting, difficulty reading) | | | | Dental ☐ Braces ☐ • Bridge ☐ • Plate Other | | | |
| Ear/Hearing problems? | Yes | No | | Information may be shared with appropriate personnel for health and educational purposes.<br>**Parent/Guardian Signature** **Date** | | | |
| Bone/Joint problem/injury/scoliosis? | Yes | No | | | | | |

**PHYSICAL EXAMINATION REQUIREMENTS** **Entire section below to be completed by MD/DO/APN/PA**

**HEAD CIRCUMFERENCE** **HEIGHT** **WEIGHT** **BMI** **B/P**

**DIABETES SCREENING** (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐
**Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

**LEAD RISK QUESTIONNAIRE** Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
**Questionnaire Administered ?** Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** (Blood test required if resides in Chicago.)

**TB SKIN OR BLOOD TEST** Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. **No test needed** ☐ **Test performed** ☐
**Skin Test: Date Read** / / **Result: Positive** ☐ **Negative** ☐ **mm** _____
**Blood Test: Date Reported** / / **Result: Positive** ☐ **Negative** ☐ **Value** _____

| **LAB TESTS** (Recommended) | Date | Results | | Date | Results |
|---|---|---|---|---|---|
| Hemoglobin or Hematocrit | | | Sickle Cell (when indicated) | | |
| Urinalysis | | | Developmental Screening Tool | | |

| **SYSTEM REVIEW** | **Normal** | **Comments/Follow-up/Needs** | | **Normal** | **Comments/Follow-up/Needs** |
|---|---|---|---|---|---|
| **Skin** | | | **Endocrine** | | |
| **Ears** | | | **Gastrointestinal** | | |
| **Eyes** | | Amblyopia Yes☐ No☐ | **Genito-Urinary** | | LMP |
| **Nose** | | | **Neurological** | | |
| **Throat** | | | **Musculoskeletal** | | |
| **Mouth/Dental** | | | **Spinal Exam** | | |
| **Cardiovascular/HTN** | | | **Nutritional status** | | |
| **Respiratory** | | ☐ Diagnosis of Asthma | **Mental Health** | | |
| Currently Prescribed Asthma Medication:<br>☐ Quick-relief medication (e.g.Short Acting Beta Antagonist )<br>☐ Controller medication (e.g. inhaled corticosteroid) | | | **Other** | | |

**NEEDS/MODIFICATIONS** required in the school setting

**DIETARY** Needs/Restrictions

**SPECIAL INSTRUCTIONS/DEVICES** e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

**MENTAL HEALTH/OTHER** Is there anything else the school should know about this student?

If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

**EMERGENCY ACTION** needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?

**Yes** ☐ **No** ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified,please attach explanation.)
**PHYSICAL EDUCATION** **Yes** ☐ **No** ☐ **Modified** ☐ **INTERSCHOLASTIC SPORTS** (for one year) **Yes** ☐ **No** ☐ **Limited** ☐

**Print Name** (MD,DO, APN, PA) **Signature** **Date**

**Address** **Phone**

**(Complete both sides)**

**Trinity Day Care**

*"Working Together to Provide a Secure, Nurturing, Educational Environment for Children and Families."*

# Trinity Day Care Payment Contract

**Fee Structure**

Under 2 .....$58.00 daily / $290.00 weekly
2 years old.....$46.00 daily / $230.00 weekly
3 to 12 years old - all day .....$39.00 daily / $195.00 weekly
School Age .....$20.00 daily / $100.00 weekly

**Payment Policy**

- **Payment is due in advance of service in order for your child(ren) to attend. The first week of tuition is due prior to attendance.**
- We offer a variety of payment schedules for your convenience. You may choose the schedule that works best for you to pay in advance of service.
- Fees are payable in the office by cash, check, credit card, and ACH payments are accepted. A processing fee is assessed according to the following schedule for credit and debit card payments: $1.00 for payments $1.00 to $100.00, $3.00 for payments $101.00 to $400.00, and $5.00 for payments $401.00 and up.
- Updated billing statements are emailed by Thursday. It is your responsibility to open statements.
- Full payment is required regardless of attendance or holidays with the exception of vacation (1 week per child per calendar year). Please check in with us for more details on how to utilize your vacation days.

**Communication is the key.** Our business office is open from 6:30 a.m. to 5:30 p.m. to help you and your family work out the best possible options/solutions to meet your needs when it comes to childcare services.

**Cancellation of Services:** A two week notice is required to cancel services at Trinity Day Care. If a two week notice is not given, we reserve the right to charge you for the two weeks.

**Additional Service:** For unexpected hardships of a more significant nature, a charitable grant application is available and funding is offered on a limited basis for those who apply.

**Choose your payment schedule below. Payment is made in advance of service being used no matter which schedule you choose.** (For CCAP parent co-payments, the formula used to determine payment amounts is the same formula used by CCAP to find the most accurate average weekly payment taking into consideration some months have 4 weeks and others have 5 weeks.)

_____ **Weekly Payments** are due on or before every Friday prior to the week of service.
_____ **Bi-Weekly Payments** are due on or before the Friday prior to the upcoming two weeks of service.
_____ **Monthly Payments** are due on the 1st business day of the month for the entire month of service.

If you are opting for the ACH payment method, you also need to complete the ACH Service Agreement Contract.

**I, _____, understand and agree to comply with this payment contract. I**
(Print Name)
**understand that I am ultimately responsible for the day care cost. I understand that in the event any unpaid balance is placed for collections, with any 3rd party collection agency, and/or placed with an attorney to obtain judgment or otherwise satisfy payment of this account, all collection fees, attorney fees, filing fees, interest, and court costs will be added to the total amount due.**

_____ _____
Signature Date

**Trinity Day Care**

*"Working Together to Provide a Secure, Nurturing, Educational Environment for Children and Families."*

# Recurring ACH Payment Authorization

**You authorize regularly scheduled charges to your credit card or bank account, please check one.** You will be charged the amount indicated below each billing period. A receipt for each payment will be provided to you and the charge will appear on your credit card or bank account statement. You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment begin collected.

I _____ hereby authorize Trinity Day Care to charge _____, on
(Full Name) (Amount)

my credit card or bank account on a _____ basis, starting on_____.
(weekly, bi-weekly, etc) (Date)

## Billing Details

Billing Address _____ Phone # _____

City, State, Zip _____ Email _____

## Please select one option:

### ☐Credit Card Details (fee charged $1-100=$1, $101-400=$3, $401-up=$5)

☐ Visa ☐ Mastercard

Cardholder's Name _____

Credit Card Number _____

Expiration Date _____/_____

Security Code (CVV) _____

### ☐Bank Account Details

☐ Checking ☐ Savings

Account Name _____

Bank Name _____

Account Number _____

Routing Number _____


I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Trinity Day Care in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that Trinity Day Care may at its discretion attempt to process the charge again within 30 days, and agree to an additional $25.00 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE _____ DATE _____
(Account Holder's Signature)

Revised 6/2022