THE UPPER ROOM

AFTER-SCHOOL PROGRAM

Académie Lafayette Parents:

The Upper Room is excited to work with your children this year through our comprehensive After-School Program. In partnership with Académie Lafayette, we look forward to providing academic and socially enriching activities for your child.

As part of the application process, you will find two enrollment applications for our program. The registration fee is $25.00 per family, which can be paid through Paypal. Because our sites are licensed locations, all participants are required to complete the Missouri Department of Health and Senior Services Child Care Enrollment Form. You will find that application below.

Also, below there is a Child Care Application for consideration of subsidy assistance through the Department of Social Services. The subsidy application is provided to help offset child care costs for those who meet income guidelines. This application requires additional documentation (pay stubs and work schedule) needed to process the application. For those families who believe they may qualify for the subsidy, you must complete this application, as well as the licensing application mentioned above.

Once the application(s) is complete, please save and email, along with any supporting documentation (if required), to afterschool@scr-upperroom.org.

We look forward to a rewarding school year and successful partnership!

Child's Name:_____

Child's Age: _____ **Child's Grade:**_____

Campus Location:_____

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION / BUREAU OF COMMUNITY FOOD & NUTRITION ASSISTANCE

CHILD CARE ENROLLMENT FORM

FACILITY/PROVIDER NAME	ADMISSION DATE	DISCHARGE DATE
CHILD'S NAME	GENDER	BIRTHDATE
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

IDENTIFYING INFORMATION

MOTHER'S/GUARDIAN'S NAME	HOME TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE ☐	CELL PHONE NUMBER
E-MAIL ADDRESS	
EMPLOYER OR SCHOOL ATTEND	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

FATHER'S/GUARDIAN'S NAME	HOME TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE ☐	CELL PHONE NUMBER
E-MAIL ADDRESS	
EMPLOYER OR SCHOOL ATTEND	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

EMERGENCY CONTACT AND PERSONS AUTHORIZED TO TAKE CHILD FROM FACILITY

(OTHER THAN PARENT) AT LEAST ONE EMERGENCY CONTACT IS REQUIRED.

NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

COMMENTS ON CHILD'S DEVELOPMENT

(PERSONAL DEVELOPMENT, BEHAVIOR, PATTERNS, HABITS, & INDIVIDUAL NEEDS)

CACFP REQUIREMENT

RELATED CHILD

☐ YES ☐ NO — HOW IS CHILD RELATED TO CHILD CARE PROVIDER?

CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED

	CHECK HERE WHAT DAYS THE CHILD WILL ATTEND. WILL CHILD ATTEND: ☐ FULL TIME OR ☐ PART TIME	WHAT TIME DOES YOUR CHILD USUALLY ARRIVE EACH DAY? CIRCLE AM OR PM	WHAT TIME DOES YOUR CHILD USUALLY LEAVE EACH DAY? CIRCLE AM OR PM	WRITE ANY COMMENTS, CHANGES OR VARIATIONS IN USUAL ATTENDANCE IN THIS SECTION INCLUDING SHIFT CHANGES.
MONDAY	☐	AM PM	AM PM	
TUESDAY	☐	AM PM	AM PM	
WEDNESDAY	☐	AM PM	AM PM	
THURSDAY	☐	AM PM	AM PM	
FRIDAY	☐	AM PM	AM PM	
SATURDAY	☐	AM PM	AM PM	
SUNDAY	☐	AM PM	AM PM	

CACFP REQUIREMENT

CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS FACILITY

☐ BREAKFAST ☐ MORNING SNACK ☐ LUNCH ☐ AFTERNOON SNACK ☐ SUPPER ☐ EVENING SNACK ☐ NONE

CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS FACILITY

☐ NEW YEARS'S DAY (JANUARY)	☐ MARTIN LUTHER KING JR.'S BIRTHDAY (JANUARY)	☐ PRESIDENT'S DAY (FEBRUARY)	☐ EASTER (MARCH/APRIL)
☐ MEMORIAL DAY (MAY)	☐ INDEPENDENCE DAY (JULY)	☐ LABOR DAY (SEPTEMBER)	☐ COLUMBUS DAY (OCTOBER)
☐ VETERANS DAY (NOVEMBER)	☐ ELECTION DAY (NOVEMBER)	☐ THANKSGIVING (NOVEMBER)	☐ CHRISTMAS DAY (DECEMBER)

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I UNDERSTAND THAT I WILL BE NOTIFIED AT ONCE IN CASE OF AN EMERGENCY WITH MY CHILD, AND I WILL MAKE ARRANGEMENTS FOR MEDICAL CARE OF MY CHILD WITH THE PHYSICIAN OR HOSPITAL OF MY CHOICE.

IF I CANNOT BE REACHED TO MAKE NECESSARY ARRANGEMENTS, OR IN A CRITICAL EMERGENCY REQUIRING MEDICAL CARE, I AUTHORIZE

_____
DAY CARE PROVIDER OR HOME PROVIDER

TO CONTACT THE FOLLOWING:

PHYSICIAN OR CLINIC

NAME	TELEPHONE NUMBER

PREFERRED HOSPITAL

NAME	TELEPHONE NUMBER

ACKNOWLEDGEMENTS

A	I HAVE RECEIVED A COPY OF THIS FACILITY'S POLICIES PERTAINING TO THE ADMISSION, CARE AND DISCHARGE OF CHILDREN.	PARENT/GUARDIAN INITIALS
B	I HAVE BEEN INFORMED THAT A COPY OF THE LICENSING RULES FOR CHILD CARE HOMES OR THE LICENSING RULES FOR GROUP CHILD CARE HOMES AND CENTERS IS AVAILABLE AT THIS FACILITY FOR REVIEW.	PARENT/GUARDIAN INITIALS
C	THE PROVIDER AND I HAVE AGREED ON A PLAN FOR CONTINUING COMMUNICATION REGARDING MY CHILD'S DEVELOPMENT, BEHAVIOR, AND INDIVIDUAL NEEDS.	PARENT/GUARDIAN INITIALS
D	WHEN MY CHILD IS ILL, I UNDERSTAND AND AGREE THAT S/HE MAY NOT BE ACCEPTED FOR CARE OR REMAIN IN CARE.	PARENT/GUARDIAN INITIALS
E	I UNDERSTAND THAT, BEFORE THE FIRST DAY OF ATTENDANCE BY MY CHILD, I WILL PROVIDE PROOF OF COMPLETED AGE-APPROPRIATE IMMUNIZATIONS OR EXEMPTION FROM IMMUNIZATIONS.	PARENT/GUARDIAN INITIALS
F	I ☐ DO ☐ DO NOT GIVE PERMISSION FOR FIELD TRIPS/EXCURSIONS. I UNDERSTAND I WILL BE NOTIFIED IN ADVANCE WHEN THEY ARE PLANNED.	PARENT/GUARDIAN INITIALS
G	I ☐ DO ☐ DO NOT GIVE PERMISSION FOR THE FACILITY TO TRANSPORT MY CHILD.	PARENT/GUARDIAN INITIALS
H	I HAVE BEEN INFORMED AND HAVE RECEIVED A COPY OF THE FACILITY'S SAFE SLEEP POLICY WHEN ENROLLING A CHILD LESS THAN ONE (1) YEAR OF AGE.	PARENT/GUARDIAN INITIALS
I	I HAVE BEEN NOTIFIED THAT I MAY REQUEST NOTICE AT INITIAL ENROLLMENT OR ANY TIME THERE AFTER WHETHER THERE ARE CHILDREN CURRENTLY ENROLLED IN OR ATTENDING THE FACILITY FOR WHOM AN IMMUNIZATION EXEMPTION HAS BEEN FILED.	PARENT/GUARDIAN INITIALS
PARENT'S/GUARDIAN'S SIGNATURE ▸		DATE

CACFP REQUIREMENT

FIRST ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
SECOND ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
THIRD ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE

Missouri Department of SOCIAL SERVICES

Your Potential. Our Support.

RESET

IMPORTANT INFORMATION REGARDING YOUR APPLICATION FOR CHILD CARE SUBSIDY

Including the following documents when mailing or dropping off a child care application, can assist in processing the application in a timely manner:

Citizenship/Relationship

- Citizenship or Immigration Status – if not a United States Citizen, documentation that verifies your legal status in the United States.
- Birth Certificates – if children are born out of state, original birth certificate from the state/country child was born in.

Income

Both earned and unearned income must be verified for all household members included in the eligibility unit.

- Pay check stubs (at least last 30 days and continuous pay periods)
- If new employment, a letter on company letterhead, from the employer stating the number of hours you will be working during a pay period and how often you will be paid. Should also include the date of your first paycheck
- Social Security/Supplemental Security Income – award letter or other verification from the Social Security Administration.
- Child Support income – can usually be verified through the state computer system; however, if you receive child support from a different state, verification will be needed.
- Self-employment – current tax return along with any supporting schedules that were filed.
- Education – documentation for all grants/scholarships/loans you have received to attend school.

If you are uncertain if something is needed to verify income, it is better to submit all documentation/verification you have.

Need for Child Care

To be eligible for child care, there must be a need for all adults in the household or a documented special need for a child. The following are considered valid needs for child care and the verification needed:

- Employment – a copy of your work schedule from your employer, or a letter from the employer on company letterhead, stating the days and hours each day that you work.
- School – A copy of a class schedule to include times and days of week attended. When a class schedule changes a new one must be submitted.
- Training – if you are enrolled in a training through a local agency/program, a copy of the training schedule with days and hours of attendance
- Incapacitated Care Taker – a physician's statement explaining you are unable to care for your child due to a mental or physical disability
- Child with a Special Need for Care – if you do not have a traditional need for care (employment, school, etc.) but have a child that has been classified as having a special need and that child has a special need for care, a medical professional must submit a statement regarding the reason care is needed and the duration of the need for care.

Child Care Provider Name – If you have chosen the child care provider or facility your child will be attending, please provide the name, address, phone number and/or DVN of that provider.

If you need assistance finding a child care provider, you may contact Child Care Aware of Missouri ® at (800) 200-9017 or visit the website at http://mo.childcareaware.org/. You may also visit the Department of Health and Senior Services' Show Me Child Care Provider search at http://health.mo.gov/safety/childcare/.

Social Security Numbers (SSN)

A SSN is NOT required as a condition of eligibility for Child Care Subsidy. Disclosure of SSN is strictly voluntary and will not affect your eligibility for Child Care Subsidy. Child Care Subsidy cannot be denied because you decide that you do not want to disclose your SSN or the SSN for any household member, including children whom benefits are requested. However, if you are applying for other benefits, along with Child Care Subsidy, your SSN may be required.

CHILD CARE APPLICATION

Need help with your application? Call us at 1-855-373-4636. If you need help in a language other than English, tell the customer service representative the language you need. TTY user can call 1-800-735-2966. If you are blind or visually impaired and would like information regarding Rehabilitation Services for the Blind, please call 1-800-592-6004.

INSTRUCTIONS: List your address and any phone numbers where you may be reached.

Applicant Full Legal Name		Date	
Home address	City	State	Zip
Mailing address, if different	City	State	Zip

Primary phone number	What kind of phone is this? ☐ cell ☐ home ☐ work ☐ other
Alternate phone number	What kind of phone is this? ☐ cell ☐ home ☐ work ☐ other
Email Address	Preferred method of contact? ☐ *call ☐ text ☐ email ☐ mail *We will call your primary phone unless you note otherwise

INSTRUCTIONS: List all persons who live at your address including yourself. **List yourself first**. Answer all questions about each person.

Full Legal Name (First, Middle, Last)	Date of Birth	Race	Gender	Marital Status	SSN (Optional for Child Care)	Relationship to Head of EU
						Head of Eligibility Unit

Are the above household members Missouri residents and do they intend to remain in Missouri? ☐ Yes ☐ No

If no please explain:

INSTRUCTIONS: List all persons who have earned or unearned income in your household.

Name	Source	Monthly Gross Income	Hourly Pay Rate	Tips Per Pay Period	Pay Frequency

Are you receiving other State or Federal assistance?	☐ Yes ☐ No If yes, explain:_____ amount:_____
Are any changes in income expected?	☐ Yes ☐ No If yes, explain:_____ amount:_____
Do you pay a health insurance premium?	☐ Yes ☐ No If yes, premium frequency: _____ amount:_____
Do you pay a dental insurance premium?	☐ Yes ☐ No If yes, premium frequency: _____ amount:_____
Do you pay a vision insurance premium?	☐ Yes ☐ No If yes, premium frequency: _____ amount:_____
Do you have more than $1,000,000 in assets?	☐ Yes ☐ No

Please provide information concerning your child care provider(s) in the areas provided. Under each provider you list, include the information for each child under that provider's care. Please ensure you list the provider's relationship to each child you list with that particular provider (i.e. grandmother, no relation).

Name of Provider 1	DVN	Phone Number	
Street Address	City	State	Zip
Name of Provider 2	DVN	Phone Number	
Street Address	City	State	Zip

Is your child(ren) enrolled in Early Head Start or Head Start? ☐ Yes ☐ No

Please list the number of days per week each child is in care for each category listed below:

Child's Name (first, middle, last)		5 or more hours		3 to 5 hours		Less than 3 hours	
	Relationship To Provider	Daytime (6am-6:59pm)	Evening/Weekend (7pm-5:59am) (Saturday/Sunday)	Daytime (6am-6:59pm)	Evening/Weekend (7pm-5:59am) (Saturday/Sunday)	Daytime (6am-6:59pm)	Evening/Weekend (7pm-5:59am) (Saturday/Sunday)
1.							
2.							
3.							
4.							
5.							
6.							

THE NEED FOR CHILD CARE IS BECAUSE YOU OR A HOUSEHOLD MEMBER IS: (CHECK **ALL** BOXES THAT APPLY)

☐ employed? Where _____ Phone Number _____ Name _____

☐ attending school? Where _____ Phone Number _____ Name _____

☐ in job training? Where _____ Phone Number _____ Name _____

☐ being evaluated for training and/or employability?
Where _____ Phone Number _____ Name _____

☐ disabled? Can you care for your child(ren) _____

☐ I am homeless (Defined as individuals who lack a fixed, regular, and adequate nighttime residence)

☐ Your child has a "special need" for child care? (i.e. child is classified as having a special need, there is no traditional need for care, but a medical professional has determined the child needs to be in child care.)

- My signature below certifies under penalty of perjury that all information given is true, correct and complete to the best of my knowledge.
- I understand that I am entitled to fair and equal treatment regardless of race, color, religion, national origin, sex, ancestry, age, sexual orientation, veteran status, or disability.
- I agree to provide any additional information or verification that is requested to determine my eligibility within 15 days of application date.
- I agree to report changes in my income if it exceeds 85% of the State Median income.
- I understand that the statements I have made are subject to investigation and verification.
- I also understand that the laws of Missouri provide for fine or imprisonment or both for persons who knowingly receive or attempt to receive public assistance they are not entitled to or who knowingly fail to report information required to determine eligibility for public assistance.

By signing this application on paper or electronically, you are giving us permission to deliver, or cause to be delivered, phone calls to you regarding your case from an automated dialing system at the primary phone number you provided on Page 2. You do not have to consent to this as part of your application. If you want to opt out of getting these calls, check here: ☐

SIGNATURE OR MARK OF APPLICANT: **DATE**

WITNESS TO MARK: **DATE**