Dear Parents/Guardians,

Thank you for your interest in **Upper Room's After School Program.** We are excited to partner with you in providing your child(ren) with quality, engaging, and reliable after school care.

To complete enrollment for your child(ren), please submit the following required items:

Enrollment Requirements

1. **$25 Registration Fee** (per family) – due on or before your child's start date.
2. **Completed Enrollment Form** (all fields must be completed).
3. **Photography and Videotaping Release Form.**
4. **School Age Child Health Report.**
    - If your child has any special health or medical needs, please upload a care plan provided by your child's doctor or school.
5. **Authorization For Release of Health/Medical Records**

Additional Information

- **Parent Handbook** – Please review the handbook for our program policies and procedures.
- **State Subsidy Families** – If you receive state assistance for tuition, please notify your case worker immediately and provide them with Upper Room's DVN number(s).
    - **Childcare Authorization Office:** (855) 373-4636
    - **DVN Numbers:**
        - AL Cherry – 003009167
        - AL Oak – 003009185
        - Holy Cross – 002482282

Click here to access the Parent Handbook and required forms.

We're Here to Help

Thank you again for choosing Upper Room as your after school childcare provider. If you have any questions or need assistance with the enrollment process, please contact us at:

(816) 363-3819
afterschool@upperroomkc.org

We look forward to welcoming your family to our program!

Sincerely,
Upper Room After School Program Team

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD – CHILD CARE COMPLIANCE

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF COMMUNITY FOOD & NUTRITION ASSISTANCE

CHILD CARE ENROLLMENT FORM

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

IDENTIFYING INFORMATION

PARENT/GUARDIAN NAME	TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS CHILD'S ADDRESS ☐	
EMAIL ADDRESS	
EMPLOYER OR SCHOOL	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

PARENT/GUARDIAN NAME	TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS CHILD'S ADDRESS ☐	
EMAIL ADDRESS	
EMPLOYER OR SCHOOL	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

If you or a member of your immediate family ever served in the U.S. Armed Forces, click here for more information about military-related services in Missouri or visit www.dese.mo.gov/veterans-services.

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 NUMBER(S)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBER(S)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

COMMENTS ON CHILD'S DEVELOPMENT (PERSONAL DEVELOPMENT, BEHAVIOR, PATTERNS, HABITS, & INDIVIDUAL NEEDS)

CACFP REQUIREMENT

RELATED CHILD

☐ Yes ☐ No	CHILD'S RELATION TO CHILD CARE PROVIDER

ETHNIC AND RACE INFORMATION (YOU ARE NOT REQUIRED TO ANSWER THIS SECTION)

Are you of Hispanic or Latino origin? ☐ Yes ☐ No

What is your race? (Select one or more.)	☐ American Indian or Alaskan native	☐ Asian	☐ Black or African American	☐ Native Hawaiian or other Pacific Islander	☐ White

CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED

Will child attend: ☐ Full time ☐ Part time Check what days your child will attend.		When does your child usually arrive each day?	When does your child usually leave each day?	Describe any changes or variations in usual attendance, including shift changes.
Monday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Tuesday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Wednesday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Thursday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Friday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Saturday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Sunday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	

MEALS YOUR CHILD IS USUALLY GIVEN AT THIS FACILITY

☐ Breakfast ☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐ Supper ☐ Evening snack ☐ None

HOLIDAYS YOUR CHILD IS IN CARE AT THIS FACILITY

☐ New Year's Day	☐ Easter	☐ Labor Day
☐ Martin Luther King, Jr.'s Birthday	☐ Truman Day	☐ Columbus Day
☐ Lincoln's Birthday	☐ Memorial Day	☐ Veterans Day
☐ Washington's Birthday	☐ Juneteenth	☐ Thanksgiving Day
	☐ Independence Day	☐ Christmas Day

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I understand that I will be notified at once in the event 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 the necessary arrangements, or in a critical emergency requiring medical care, I authorize

_____

(CHILDCARE FACILITY NAME)

to contact the following:

PHYSICIAN OR CLINIC

NAME	TELEPHONE NUMBER

PREFERRED HOSPITAL

NAME	TELEPHONE NUMBER

ACKNOWLEDGMENTS

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 home 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 that 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 at any time thereafter whether there are children currently enrolled in or attending the facility for whom an immunization exemption has been filed.	PARENT/GUARDIAN INITIALS

PARENT/GUARDIAN 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

USDA Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   program.intake@usda.gov

This institution is an equal opportunity provider.

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD - CHILD CARE COMPLIANCE

SCHOOL-AGE CHILD HEALTH REPORT

IDENTIFYING INFORMATION

CHILD'S NAME	BIRTHDATE

HEALTH STATEMENT (CHECK ONE)

☐ My child is in good health, is able to participate in group care, has no special health or medical requirements.

☐ My child is able to participate in group care but has special health or medical requirements as listed below.

SCHOOL-AGE CHILD'S SPECIAL HEALTH OR MEDICAL REQUIREMENTS

PLEASE LIST ANY ALLERGIES, SPECIAL MEDICAL CONDITIONS, INCLUDING CHRONIC HEALTH PROBLEMS (SUCH AS ASTHMA, SEIZURES), BEHAVIORAL DISORDERS, SPECIAL NEEDS, ETC.

PARENT OR LEGAL GUARDIAN SIGNATURE	DATE

TO BE FILED IN CHILD'S RECORD AT CHILD CARE FACILITY.

MISSOURI DEPARTMENT OF SOCIAL SERVICES

AUTHORIZATION FOR RELEASE OF MEDICAL/HEALTH INFORMATION

I, _____ do hereby authorize and request
(NAME OF INDIVIDUAL, GUARDIAN, LEGAL OR PERSONAL REPRESENTATIVE)

that _____ release or disclose to
(NAME OF ENTITY, AGENCY OR INDIVIDUAL HOLDING THE RECORDS)

UPPER ROOM
_____ the health information specified
(NAME OF ENTITY, AGENCY, INDIVIDUAL OR CLASS INTENDED TO RECEIVE THE INFORMATION)

below that relates to the following individual:

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

ADDRESS, CITY, STATE	OTHER ID

THE SPECIFIC INFORMATION TO BE DISCLOSED IS (CHECK ALL THAT APPLY)

- ☐ Entire Record
- ☐ Treatment or Tests
- ☐ Laboratory Reports
- ☐ Psychological Evaluation
- ☐ Medical History, Examination, Diagnosis
- ☐ Hospital Records Including Reports
- ☐ Immunizations/Allergy Records
- ☐ Mental Health Records/Reports
- ☐ Prescriptions
- ☐ X-ray Reports
- ☐ Healthcare Payments
- ☐ Other (Specify): _____

INCLUDE INFORMATION WITHIN THE FOLLOWING DATE(S)

EXPIRATION DATE

This authorization is good until the date(s) _____ , or for one year.

PURPOSE OF REQUEST FOR DISCLOSURE

- ☐ At the request of the individual or the individual's legal representative
- ☐ Other (Specify): _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

You can not be required to sign this disclosure authorization form nor may treatment or payment be refused if you do not sign, but if you sign this form you must be given a copy. You have the right to inspect the information to be disclosed and you may revoke this authorization by writing the DSS Privacy Officer at PO Box 1527, Jefferson City, MO 65102. A revocation of this authorization will not reverse disclosures already made under this authorization and when a disclosure occurs, there is a possibility the information might be re-disclosed by the recipient. For more information you may call 573-751-1334. (TDD 800-735-2966 or 800-735-2466 - Voice access to Relay Missouri).

SIGNATURE

I have had an opportunity to review and understand the content of this authorization form, and by signing this authorization, I confirm it accurately reflects my wishes. If a guardian, legal representative or a personal representative signs this document they must provide separate documentation of their status and authority.

SIGNED (INDIVIDUAL, GUARDIAN, LEGAL OR PERSONAL REPRESENTATIVE	DATE

ADDRESS

UPPERROOM
upperroomkc.org
(816) 363.3819
300 E. 39TH STREET
KANSAS CITY, MO 64111

LIGHTS, CAMERA, ACTION

CONSENT AND RELEASE

Upper Room KC, local news media or community service organizations may take photographs of Upper Room participants. These photos, audio and/or video tapes may be used in various forms of advertising or media (brochures, magazines, orientation, training, public television or newspaper). I give permission for Upper Room KC or its agents to use any photographs and/or audio/videotape including my child for any lawful media purpose without compensation.

☑ Permission Granted
☐ Permission Denied

Child's Name

_____ _____

_____ _____

_____ _____

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Child Care Provider Signature Date

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION

OFFICE OF CHILDHOOD — CHILD CARE SUBSIDY

APPLICATION FOR CHILD CARE SUBSIDY FOR CHILDREN AND FAMILIES

INSTRUCTIONS

The Department of Elementary and Secondary Education (DESE) Child Care Subsidy Program aims to increase children's access to early learning by assisting eligible families with payments for child care in Missouri. This program helps families with the cost of child care so they are able to focus on finding and holding steady jobs or attending school and training programs. You can read more about the eligibility requirements, fees, and services in the Child Care Subsidy Program brochure at: https://dese.mo.gov/media/pdf/child-care-subsidy-brochure.

Parents/guardians who want to apply for child care assistance must complete this form or submit an application online at: childcare.mo.gov/s/parent-landing.

The following documents must be mailed along with this form, or uploaded in the online application:

- Proof of applicant's residency (e.g., the applicant's Photo ID or current utility bill)
- Copy of income verification*
  - Documents must be dated within the last 60 days (e.g., the applicant's paystubs, child support letter/printout, unemployment letter/printout, tax forms, Social Security award letter)
  - Applicants of children receiving protective services are exempt from this requirement

Return the completed, signed form and any additional documents to:

Missouri Child Care Subsidy Program
PO Box 527
Hillsboro, MO 63050

The application will be reviewed within 15 days of receipt of the completed form and processed within 30 days. Applicants will be notified of their eligibility using the contact information listed in the application.

Important! A social security number (SSN) is not required as a condition of eligibility for child care assistance. An application for child care assistance shall not be denied or placed in pending status because of failure or refusal to disclose their SSN or the SSN for any household member, including the child for whom child care assistance is requested.

If you or a member of your immediate family ever served in the U.S. Armed Forces, click here for more information about military-related services in Missouri or visit https://dese.mo.gov/veterans-services.

APPLICANT INFORMATION

List your full legal name, address, phone number, and email address.

Applicant Name *(Prefix, First, Middle, Last, Suffix)*			Date
Home Address	**City**	**State**	**Zip Code**
Mailing Address *(if different)*			

Phone Number	Check phone type ☐ Cell ☐ Home ☐ Work ☐ Other
Alternate Phone Number	Check phone type ☐ Cell ☐ Home ☐ Work ☐ Other
Email Address	☐ Check here if you do not want to receive text messages

The Department of Elementary and Secondary Education does not discriminate on the basis of race, color, religion, gender, gender identity, sexual orientation, national origin, age, veteran status, mental or physical disability, or any other basis prohibited by statute in its programs and activities. Inquiries related to department programs and to the location of services, activities, and facilities that are accessible by persons with disabilities may be directed to the Jefferson State Office Building, Director of Civil Rights Compliance and MOA Coordinator (Title VI/Title VII/Title IX/504/ADA/ADAAA/Age Act/GINA/USDA Title VI), 5th Floor, 205 Jefferson Street, P.O. Box 480, Jefferson City, MO 65102-0480; telephone number 573-526-4757 or TTY 800-735-2966; email civilrights@dese.mo.gov.

HOUSEHOLD INFORMATION

List the persons living at your address. Put your name and information on the first line.

Name	Relationship to Applicant *(Spouse, Partner, Child, Other Related, Other Non-Related)*	Date of Birth	Gender *(Female, Male, Other)*	Race *(Asian, Black, White, Native, Hawaiian)*	Ethnicity *(non-Hispanic, Hispanic or Latino)*	Marital Status *(Single, Married, Divorced, Widowed)*	DCN or SSN	Primary Language	Military Service *Y or N*
	Self								

INCOME AND ALLOWABLE EXPENSES

List all persons in your household with earned or unearned income (e.g., wages, child support, Social Security).

Name	Income Source	Start Date	Hourly Rate of Pay	Gross Monthly Income	Pay Frequency

Are changes in your income expected? ☐ Yes ☐ No	If yes, explain:
Do you typically work overtime? ☐ Yes ☐ No	If yes, explain:
Do you pay for medical insurance? *(health, dental, vision)* ☐ Yes ☐ No	If yes, how much per month?
Do you have more than $1,000,000 in assets? ☐ Yes ☐ No	If yes, explain:
Are you receiving any other State or Federal benefits? ☐ Yes ☐ No	If yes, select all that apply: ☐ Temporary Assistance (TANF) ☐ Food Stamps (SNAP) ☐ SSI/Blind Pension ☐ Medicaid (MOHealthnet) ☐ Public Housing/Section 8 ☐ Pre-Kindergarten

PROVIDER INFORMATION

List the name of the child care provider and their contact information, if known.

Provider #1 Name	DVN	Phone Number	Email
Address	City	State	Zip
Provider #2 Name	DVN	Phone Number	Email
Address	City	State	Zip

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

List the start and stop times care is needed each day (include travel, sleep, and study time):

Monday	Start:	End:	**Total Hours:**
Tuesday	Start:	End:	**Total Hours:**
Wednesday	Start:	End:	**Total Hours:**
Thursday	Start:	End:	**Total Hours:**
Friday	Start:	End:	**Total Hours:**
Saturday	Start:	End:	**Total Hours:**
Sunday	Start:	End:	**Total Hours:**

ATTESTATION

I am submitting this application to find out if my household is eligible for child care assistance.

By inserting my initials, I confirm I have read and understand the following statements:

_____ 1. I have read the subsidy eligibility criteria and policies found at https://dese.mo.gov/childhood/child-care-subsidy/child-care-manual.

_____ 2. I certify that any information or documentation submitted is true and accurate to the best of my knowledge.

_____ 3. I understand that the statements I have made are subject to investigation and verification. I agree to provide any information or verification requested to determine my eligibility.

_____ 4. I understand that giving false information or failing to provide complete and correct information can also result in an overpayment and recoupment of some or all of the payment and could result in my prosecution for fraud.

_____ 5. I understand that child care subsidy eligibility is based on income and I agree to report any change in my income.

_____ 6. I understand that I have a right to appeal and have a hearing if I am determined ineligible.

Signature of Applicant	**Date of Signature**