MEETING OUR COMMUNITY'S NEEDS

YMCA OF WESTERN STARK COUNTY

TEMPORARY PANDEMIC CHILD CARE CENTERS

The closure of Ohio's school districts has caused significant impact on the families of critical employees throughout our community. While others are able to self-isolate, these employees are working long shifts, isolated from family, in order to provide critical care to the community. Child care will only be provided for parents providing health, safety and other essential services.

PROGRAM

Preschool Age (ages 3-5 must be potty trained)
School Age (K - 8th Grade)

HOURS

6:00am to 6:00pm (hours may vary based on need)

REGISTRATION

Space is limited and registrations will be first come, first serve. Proof of employment must be provided upon registration. To register email completed registration forms to
jsmer@weststarky.org for Massillon Y
adoubledee@weststarky.org for Towpath Trail Y

FEES

Through the generosity of a local foundation we are able to offer income based pricing for families not receiving assistance from Ohio Family Services. See page titled Payment Agreement.

HEALTH IS OUR FIRST PRIORITY

In order to ensure we are aligning with containment efforts, we will:

- Check each child's temperature upon arrival
- Limit access to our buildings by doing drop off and pick up at the door
- Not admitting any child with an elevated temperature

LOCATIONS

MASSILLON FAMILY YMCA
131 Tremont Ave SE, Massillon
(330) 837-5116
jsmer@weststarky.org

TOWPATH TRAIL YMCA
1226 Market St NE, Navarre
(330) 879-0800
adoubledee@weststarky.org

PANDEMIC CHILD CARE REGISTRATION

Child Information

Child's Name_____Child's Birth Date ____/____/____ Age____

Child's Nickname_____ Gender ○Female ○Male

Home Phone _____

Child's School or prior Day Care:_____

Grade (2019-2020) _____

Parent/ Guardian Information

If there is custody issues involved with your child, you must provide the center directors with full court papers indicating who has permission to pick up the child. The program may not deny a parent access to his/her child without proper documentation. Everyone picking up a child (including parents) must provide a photo I.D. upon request.

Name_____ Name_____

D.O.B._____ D.O.B._____

Home_____ Home_____

Work_____ Work_____

Cell_____ Cell_____

Child Lives With _____

Authorized Persons to Pick Up Child

Your child will only be released to a parent/guardian or persons listed in this section. Staff will require government issued identification before releasing your child.

Name _____ Name _____

Relationship_____ Relationship _____

Phone # _____ Phone # _____

Name _____ Name _____

Relationship_____ Relationship_____

Phone # _____ Phone # _____

JFS: Do you receive assistance from the Department of Jobs and Family Services **for Child Care**? ○NO ○YES

Schedule

Please indicate what days of the week you need care below:

○Monday ○Tuesday ○ Wednesday ○Thursday ○Friday

My schedule is (Circle one) ○Consistent ○ Variable

I am in need of care (Circle one) ○All weeks available ○Variable Weeks

Other notes about your schedule:_____

_____

PANDEMIC CHILD CARE REGISTRATION

Child's Name_____

Please Read Carefully and Respond to the Following Permission Forms

Child Drop-Off Policy/Pick-Up Policy

When you enroll your child in any YMCA child care program, it is to be understood our policy is for you to **bring your child into the program area each day, sign the attendance sheet, and let one of the staff members know your child has arrived**. Please note, we are not legally responsible for your child's supervision when he / she is dropped off outside of the building. As a parent or guardian, I am aware the YMCA staff is not responsible for my child's supervision unless I bring my child into the program area and sign him/her in upon arrival each day. I understand state law requires me to **sign my child in and out** each day. I also understand state law requires I **notify staff my child is leaving** for the day.

Parent/Guardian Signature _____ Date _____

Photograph Consent

I grant permission for my child to be video taped and/or photographed while participating in programs and activities of the YMCA. It is my understanding that video taping and photographs will be used for educational, training and promotional purposes only. I may revoke this permission at any time be sending a letter to the YMCA.

Parent/Guardian Signature _____ Date_____

Class Pet

I give permission for my child to participate in activities that involve the classroom pet(s).
Concerns for my child (ex. student allergies, other medical sensitivities, sanitation practices, etc.):_____

_____

Parent/Guardian Signature _____ Date _____

I, the undersigned parent/guardian, do hereby accept all responsibility for, and assume the risk of any injury or damage to my person or dependent children which might arise directly or indirectly as a result, and or participation in a YMCA of Western Stark County program. I hereby expressly release, discharge and hold harmless from any liability whatsoever the YMCA, the various branches and subdivisions expressly including but not limited to the Board of Trustees of the YMCA, except for injuries caused intentionally, or by willful misconduct. I certify that I am familiar with the contents of the release, that I have read and understand the same, and that it is my intention by signing this release that the same be binding not only on me, but my heirs, administrators, executors, successors, and assigns.
The YMCA of Western Stark County is not responsible for misplaced or stolen items.

Parent/Guardian Signature _____ Date_____

PANDEMIC CHILD CARE REGISTRATION

Payment Agreement

Child's Name:_____Start Date:_____

Payment Schedule / Rate Plan (place a ✓ in the ○):

Income Based Pricing

Based on household income

place a ✓ in the ○	Over $65,000	$55,000 to 64,999	$45,000 to 54,999	$30,000 to 44,999	$20,000 to 29,999	Under $20,000
Non-Member	○ 150.00	○ 135.00	○ 120.00	○ 105.00	○ 90.00	○ 75.00
Member	○ 145.00	○ 130.00	○ 115.00	○ 100.00	○ 85.00	○ 70.00

JFS: Do you receive assistance from the Department of Jobs and Family Services **for Child Care**? ○NO ○YES: Copayment $_____

Payment Policy:

1) Child care payments are due in advance of attendance for the week. This includes ODJFS weekly copayments.
2) I understand that fees are a flat rate and stay the same regardless of my child's attendance.
3) I understand I will be charged **continuously** for the program and rate plan that I signed my child up for.
4) Payments/Refunds will be applied to any overdue YMCA balances first then to current programming fees.
5) All programs close at 6:00pm. A $1 per minute per child late fee is charged after 6:00pm.
6) All policies are at the discretion of management and may be changed.
7) **JFS**: Copayments are due weekly, on Friday, and in advance of attendance.
8) **JFS**: I understand that if my authorization is not current, I will be responsible for the private pay rates.
9) **JFS**: I understand that my child must be checked in and out every day on the JFS Time, Attendance and Payment (TAP) system. If I do not, I understand I will be charged the difference between my copay and the private pay rates.
10) **JFS**: I understand that if I do not check my child in/out on the JFS TAP system I forfeit services.
11) **JFS**: I understand that ODJFS families MUST attend a minimum of 25 hours a week during the summer and 7 hours during the school year.

Returned Automatic Payments & Checks: A $15 processing fee will automatically be assessed to your account. Two or more returned payments may result in termination or require payment in full.

Parent/Guardian Signature Print Name Date

Driver's License or S.S. Number of Responsible Party:_____*required*

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Family Questionnaire

Please complete the following questions in order for us to best serve your child during their time in our programming.

1. Tell us about your family dynamic (Ex: Who lives in your household? Do you have pets?).

2. Tell us about you're family cultures and traditions (Ex: What makes your family special? What is your home language? Do you have any hobbies or skills you would be willing to share with us?).

3. What might you and/or your child be anxious about as he/she starts this program?

4. Are there any changes or transitions that your child has recently experienced or is experiencing? (Ex: Moved to a new home, Divorce, Death of a family member, friend or pet)

5. What methods do you use at home to respond to your child's negative behavior?

6. What are your expectations for your child in this program?

7. What other information might be helpful for the staff caring for your child to know?

Parent Signature: _____ **Date:**_____

Reset Form

Ohio Department of Job and Family Services

CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name		Date of Birth	First Day at Program/Home
Home Address			City
State	Zip Code	Home Telephone Number	
Parent/Guardian Name			Relationship to Child
Home Address			Home Telephone Number
City		State	Zip
Email Address *(if applicable)*		Cell Phone	
Parent's Work/School Telephone Number		Parent's Work/School Name	
Parent's Work/School Address			City

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Parent/Guardian Name			Relationship to Child
Home Address			Home Telephone Number
City		State	Zip
Email Address *(if applicable)*		Cell Phone	
Parent's Work/School Telephone Number		Parent's Work/School Name	
Parent's Work/School Address			City

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Emergency Contacts: Parents **cannot be listed** as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness **if you cannot be reached.** Any person listed should be able to assist in contacting you. At least one person listed must be within one hour of the center/home, able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

Name		Name	
City	State	City	State
Telephone Number	Relationship to Child	Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached *(if applicable)*		Other numbers where emergency contact can be reached *(if applicable)*	
Name of Physician or Clinic/Hospital			
Street Address			
City	State	Telephone Number	

Child's Name

Allergies, Special Health or Medical Conditions, and Food Supplements

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or family child care home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

☐ No

☐ Yes - check all that apply ☐ Food ☐ Medication ☐ Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms, take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Does your child have a special health or medical condition? (*check one*)

☐ No

☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication, food supplement, or medical food need to be administered at the child care center/type A home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.

☐ N/A - program does not administer any medications.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

☐ No

☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

☐ No

☐ Yes - written instructions from the child's health care provider must be on the JFS 01217 "Request for Administration of Medication."

☐ N/A - child does not attend a full time program.

Child's Name
List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff **or medical personnel** in an emergency situation**.**
List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page.

Diapering Statement

Is your child toilet trained? ☐ Yes (If yes, skip to Emergency Transportation Authorization section) ☐ No (If no, fill out the following)

The program's policy is to check diapers every _____ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

Give *Permission* to Transport			***Do Not Give Permission*** **to Transport**	
Program or Home Name Massillon YMCA			Program or Home Name	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.		**OR** **Do not sign both**	**does not have permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:	
Parent's Signature	Date		Parent's Signature	Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. ☐ Yes ☐ No
(check one)

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note: This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15 and 5101:2-13-15. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

Reset Form

Ohio Department of Job and Family Services

PANDEMIC CHILD CARE CENTER CHILD ENROLLMENT ADDENDUM

Child's Name	Child's Date of Birth	Parent's Name

Name and Address of Pandemic Child Care Center

Is Your Child Receiving Publicly Funded Child Care? ☐ Yes ☐ No	If Yes: List the Provider's Name and Address

Description of Parent's Employment Providing Health and Safety Services as defined by the Ohio Department of Job and Family Services (ODJFS). Please attach verification.

Find Your Family Size in the Chart. Is Your Income Below These Annual or Monthly Limits?

☐ Yes ☐ No

Family Size	Annual Income	Monthly Income
1	$24,980	$2,082
2	$33,820	$2,819
3	$42,660	$3,555
4	$51,500	$4,292
5	$60,340	$5,029
6	$69,180	$5,765
7	$78,020	$6,502
8	$86,860	$7,239
9	$95,700	$7,975
10	$104,540	$8,712
11	$113,380	$9,449
12	$122,220	$10,185

Signature of Parent	Date

YMCA of Western Stark County

Automatic Payment Plan *(automatic payments from a bank account or credit card)*

Participant's Information

Child's Last Name: _____ First Name: _____

Site/Location:_____ Program: _____

Do you receive assistance from the Dept. of Jobs and Family Services for Child Care? ○**NO** ○**YES**

Billing Information (This person MUST sign this form below)

Last Name: _____ First Name: _____

Phone: _____ Second Phone:_____

Draft Authorization

Form of Payment

I authorize automatic payments of my child care fees (see amount on Schedule & Payment Agreement). The drafts will occur automatically until contract is expired or terminated in writing. A minimum of 7 days' notice is required.

❑ Credit/Debit Card

Name on Account: _____

Card Type: ❒ MasterCard ❒ Visa ❒ Discover

Account Number: _____

Expiration Date: _____/_____

❑ Bank Account (attach voided check/statement)

Name on Account: _____

Account Type: ❒ Savings ❒ Checking

Routing Number: _____

Account Number: _____

Schedule of Payments

Weekly (pick one)

❒Mondays ❒Tuesdays ❒Wednesdays ❒Thursdays ❒Fridays

❒ Monthly (circle only **one** date)

❒ Semi-monthly (circle any **two**)

1	2	3	4	5	6	7	8	9	10
11	12	13	14	15	16	17	18	19	20
21	22	23	24	25	26	27	28	X	X

Agreement

1) Automatic payments are scheduled at or before each week/month starts. Monday payments are for the current week, Friday payments pay for the next week, and monthly payments are for all the Mondays on or after the day of the month chosen and each Monday until the next payment.
2) In the event my preauthorized payment is not honored on my scheduled draft date the YMCA may charge a $15 penalty for returned/late payments in addition to any charges assessed by your financial institution.
3) It is further understood that if payment is not honored, then the YMCA, at its discretion, may resubmit the amount due for payment on a future date.
4) Two or more returned payments may result in termination or require payment in full for the year.

I HAVE CAREFULLY READ THE ABOVE AGREEMENT AND AGREE TO ABIDE BY ALL OF ITS TERMS.

Signature: _____ **Date**:____/_____/_____

Site Use Only

Daxko Unit ID number:_____

JFS approval through what date:_____

Business Office Use Only

Auto Payments Entered by: _____Date:_____

❒Copy Attached OR ❒Written Used OR ❒In Daxko