FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

CENTRAL CONNECTICUT COAST YMCA

School Aged Child Care Registration & Release Form

Site Location/Program________________ Child's School________________

Number of Days______ Days of Wk M T W T F ☐Before ☐After Program Start____________ Program End____________

Child's First Name________________ Last________________ Gender________

Address________________ City________________ State ____ Zip________

Date of Birth______ ______ Age as of Sept 1, yrs.____ mos.____ Grade entering in Fall______ Child resides with____________

Parent/Guardian #1________________ Parent/Guardian #2________________

Relationship to Child________________ Relationship to Child________________

Home Address________________ Home Address________________

City/State/Zip________________ City/State/Zip________________

Place of Employment________________ Place of Employment________________

Employment Address________________ Employment Address________________

City/State/Zip________________ City/State/Zip________________

Info will be sent via email
Email Address ________________ Email Address ________________

☐ Home Phone # (   )____________ ☐ Home Phone # (   )____________

☐ Cell Phone # (   )____________ ☐ Cell Phone # (   )____________

☐ Work Phone # (   )____________ ☐ Work Phone # (   )____________

Does your child require special accommodations (social, behavioral, medicine)? No____ Yes ___ Will you be providing an individualized care plan? Yes ___ No ___

Authorization for medical attention:
I give permission for the YMCA Certified First-Aid staff to treat my child, if needed. I authorize the child care staff to consent to emergency treatment (under advice of a Connecticut licensed physician) for my child when the need for such treatment is immediate and when efforts to contact me are unsuccessful. My child will be transported to the nearest emergency facility. I understand that any expenses incurred, through transportation and the treatment of my child, are my responsibility.

Name of Physician________________ Address/Phone________________

Insurance Company________________ Policy Number________________

Policy Holder________________ Relationship to Child________________

Signature of Parent/Guardian ________________________ Date____________

Concussion Information: I have read the CDC Concussion Fact Sheet and will talk to my child about the information. (http://www.cdc.gov/headsup/)

Guardian Authorization:
In order to ensure the well-being of all our participants and our ability to help you with picking up your child, please include every person that could assume the custody of your child for any unforeseen circumstances. The YMCA WILL require photo I.D. to release any child to an authorized pick up person listed on this form. I authorize the YMCA to release my child to the custody of the following people other than Parents/Guardians listed above:

Name: ________________ Relationship: __________ Phone:__________ Phone:__________

Name: ________________ Relationship: __________ Phone:__________ Phone:__________

Name: ________________ Relationship: __________ Phone:__________ Phone:__________

The YMCA is required to permit either parent to pick up the child unless the YMCA is furnished with a court order to the contrary. Please list below any persons not authorized to pick-up this child and attach the original copy of the court order.

Name: ________________________ Relationship________________

Parent/Guardian Permission:
I understand that the Central Connecticut Coast Young Men's Christian Association, Inc. (the "Parent Company") and all of its branches are a charitable organization that makes its programs and facilities available to persons only on the condition that they agree to assume full responsibility for injury and damage. Therefore in exchange for acceptance of the child in the YMCA programs, I release, on behalf of the child, myself and members of the child's family, the YMCA, the Parent Company, and officers, directors, employees and volunteers from all claims of damage or loss to the child's property and claims of personal injury or property damage caused to others by the child, including injury or damage to YMCA property or personnel.

I understand the financial requirements, registration, payment obligations and deadlines as outlined in the School Aged Child Care Handbook.

Signature of Parent/Guardian ________________________ Date____________

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CENTRAL CONNECTICUT COAST YMCA

School Aged Child Care Authorizations and Acknowledgements

Site Location________________________________ Child's School________________________________

Child's First Name____________________________ Last____________________________ Gender__________

Parent Guardian Authorizations and Acknowledgements

I understand there are risks associated with activities and programs in which my child is a participant. I hold the Y Branch, the Central Connecticut Coast YMCA, its employees, representatives, agents, and assigns from any and all claims whatsoever against said parties resulting from or caused by my child's participation. __________ Initials

I acknowledge that I have received a copy of the YMCA Child Care Parent Handbook which covers the following information: general policies, accounting policies, days program is closed and complaint procedure. I understand that if I have any questions in regards to the content of this handbook it is my responsibility to notify the YMCA at the earliest convenience. __________Initials

I hereby give permission for my child to participate in all activities (including field trips) that are part of the program. __________Initials

I hereby give my consent for my child to participate in activities that involve water while under the supervision of the YMCA staff or their representatives. __________Initials

I hereby give my consent for my child to be transported by the YMCA staff or their representatives. I grant permission to have my child transported to one of the YMCA's other facilities in case of inclement weather. __________Initials

I understand that neither the YMCA nor any of its paid or volunteer workers can be held responsible in the events of an accident. I understand that all precautions will be taken to ensure the safety and health of my child. __________Initials

I also grant permission for photographs taken of my child while at school aged child care to be used for publicity and promotional purposes. __________Initials

I acknowledge that the school district is not responsible for incidents/accidents that occur during after-school hours. __________Initials

I understand that if I am receiving Care 4 Kids, my contract for child care and all associated fees is on file with the YMCA. If for any reason Care 4 Kids fails to pay, I, as a client of the YMCA, will be held responsible for the full child care tuition. By initialing, I agree with these terms. __________Initials

I understand that the Site Location, the Y branch and the Central Connecticut Coast YMCA are not responsible for personal property lost, damaged, or stolen while members and/or program participants are using the facilities, on the premises, or involved in Y programs. __________Initials

I understand that my monthly payment is due on the 20th of the month for the upcoming month and that a $25 late fee will be charged if my payment is not received on time. I understand that there will also be a $20 fee for any returned payments. Furthermore, I understand that if payment is not received by the 30th of the month, my child will not be allowed to attend the program until my balance is paid in full. __________Initials

Getting to know your child

The YMCA believes that *every* child in our care is a unique individual. Help us to provide the best care for your child by providing us as much information as possible. We strongly encourage you to meet with the Director and visit the program prior to enrolling your child.

Please answer the following questions:

Please explain if there are certain situations that may cause your child difficulty. How can we best work with your child in these situations?

What limitations does your child have?

Are special provisions required to enable your child to participate in our program? (Including all food allergies).

Please list all medications and/or medical conditions affecting your child. (Must complete medication administration form, individual care plan and supply site with appropriate medication prior to starting the program).

Other comments:

Signature of Parent/Guardian ________________________________ Date____________________

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FOR SOCIAL RESPONSIBILITY

CENTRAL CONNECTICUT COAST YMCA

School Aged Child Care Payment Authorizations

Site Location________________________________ Child's School________________________________

Child's First Name________________________________ Last________________________________ Gender__________

Child Care Agreement

I ________________________________, hereby authorize the Central Connecticut Coast YMCA to charge the account listed on the 20th of each month in the amount of $__________________ to act as payment for School Aged Child Care services. I understand that I must provide THIRTY DAYS notice, in writing, if I wish to discontinue this service. This agreement is for the current school year plan only and the last draft will occur on May 20, 2019. **There will be a $20.00 charge for any EFT or charge returned by the bank. Also a $25.00 late payment fee will be added to the account if not paid before the first of the month. These fees will be automatically drafted from my School Aged Child Care account.**

I understand it is my responsibility to notify the YMCA of any change in address, bank account information (if utilizing bank draft for payment of child care) or credit card information/expiration date (if utilizing credit card for payment of child care).

Please print your name ____

Address ____

Email ____

Signature ____Date__________________

I authorize my bank to honor preauthorized Electronic Funds Transfers (or credit card charges) against my account for (child care service) payments as indicated below. When the bank honors the EFT (or credit card) by charging my account, such transfer shall constitute notice of payment due and my receipt for the payment. Should any preauthorized EFT (or credit card) not be honored by said bank when received by them, then it is understood that the payment is to be made by me in the amount of said payment plus service charge. It is further understood that if such payment is not honored by the bank (or credit card institution), then the YMCA, at its discretion, may resubmit the amount due for payment on a future date.

□ I choose to utilize the EFT option for monthly payment (direct debit from my □ Checking □ Savings account)

Bank Name ______________________________ Name on Account ______________________________

Routing/Transit Number ______________________________ Account Number ______________________________

Authorized Signature: ____ Date: ____________________

□ I choose to utilize the Credit Card Payment option for monthly payment (automatic direct charge to credit card)

Credit Card Type □ American Express □ MC □ Visa Card Holder Name ______________________________
Credit Card needs to be scanned at the branch. Card Holder Address ______________________________
Authorized Signature: ____ Date: ____________________

2018-2019

SCHOOL AGED CHILD CARE ONLY

Attach voided check here.

03/2/2018

FOR YOUTH DEVELOPMENT®
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CENTRAL CONNECTICUT COAST YMCA
School Age Child Care Behavior Contract for Participants, Parents and Families

EXPECTIONS

- Show respect by treating other children and adults the way I would want to be treated.
- Be honest, will always tell the truth about actions and feelings.
- Be a friend that others can trust.
- Demonstrate caring by helping others and treating them kindly.
- Take responsibility for my own behavior and accept the consequences for my actions.
- To be free from cruel teasing and insults.
- Have a safe, calm, clean and orderly environment.
- Make mistakes without being ridiculed by others.
- Seek help from those that are there to help. Talk with Y Staff when frustrated or feel mistreated.
- Be treated with dignity and respect by everyone.
- Use appropriate, acceptable language, don't talk back or use obscene, threating language or speak in an unkind manner.
- Avoid fights or verbal abuse.
- Be fair and accepting of others eager to join any activity.
- Work and play safely.
- Be kind, considerate, helpful, and respectful toward others.
- Follow directions and listen attentively while participating in activities.
- Share equipment and materials fairly and use them properly.
- Respect property, especially things that do not belong to me.
- Cooperate with others who are there to help.
- Speak up when witnessing unfairness or offensive language or behavior of others.
- Be a good sport whether I win or lose.
- Be truthful with everyone.

CONSEQUENCES

- Letter of discipline for talking back, destroying property, bullying children, disrupting the program, refusing obey. Parent will be required to sign these reports acknowledging that they have read the report. After three reports child and parent may be required to meet with the Y Leadership Staff.
- Letter of discipline and immediately suspended for a minimum of one day for hitting, kicking, biting, spitting, scratching, swearing, making degrading or racial remarks, or leaving the group. Parents may be required to meet with the Y Director before the child can return to the program.
- Services may also be terminated if the parent is physically or verbally abusive to a staff member. It is our desire that every child enjoys his/her experience in the program.
- Participation in the School Age Child Care program may be limited or discontinued if this contract is not followed.

____ ____
Signature **Signature**

____
Date

FOR YOUTH DEVELOPMENT®
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CENTRAL CONNECTICUT COAST YMCA
School Age Child Care 2018-2019
Transportation Permission Form

I herby give permission for my child,____, give my permission for daily transportation to and from his/her school as indicated on my child's enrollment form as well as for emergency situations when the school needs to be evacuated for the safety of the children.

In the event of an emergency and I cannot be reached please call:

____at_____________________________________

(Emergency Contact) (Phone Number)

I prefer my child to be taken to _______________________________________hospital and in the event that my child requires emergency medical attention the following physician should be notified.

____

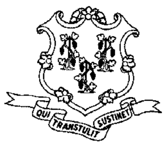
Physician's Name and number

____

Signature of Parent/ Guardian Date

CENTRAL CONNECTICUT COAST YMCA
1240 Chapel Street, New Haven, CT 06511
P 203 777 9622 **F** 203 773 8950 **W** cccymca.org

03/2/2018



State of Connecticut Department of Education

Health Assessment Record

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, a physician assistant or the school medical advisor prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity ❑ American Indian/ Alaskan Native ❑ Hispanic/Latino	❑ Black, not of Hispanic origin ❑ White, not of Hispanic origin ❑ Asian/Pacific Islander ❑ Other
Primary Care Provider		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N
Does your child have dental insurance? Y N

If your child does not have health insurance, call **1-877-CT-HUSKY**

* If applicable

Part I — To be completed by parent/guardian.

Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				Y	N	Diabetes	Y	N
Any immediate family members have high cholesterol				Y	N	ADHD/ADD	Y	N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take **in** school:

*All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.*

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian Date

To be maintained in the student's Cumulative School Health Record

Part II — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name ________________________________ Birth Date ____________ Date of Exam ____________

❑ I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

***Height** _____ in. / _____% ***Weight** _____ lbs. / _____% **BMI** _____ / _____% **Pulse** _____ ***Blood Pressure** _____ / _____

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen			***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made		
Genitalia/ hernia					
Skin					

Screenings

***Vision Screening**

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Referral made

***Auditory Screening**

Type:	Right	Left
	❑ Pass ❑ Fail	❑ Pass ❑ Fail

❑ Referral made

	Date
Lead:	
***HCT/HGB:**	
Other:	

TB: High-risk group? ❑ No ❑ Yes PPD date read: Results: Treatment:

*IMMUNIZATIONS

❑ Up to Date or ❑ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
*If yes, please provide a copy of the **Asthma Action Plan** to School*

Anaphylaxis Allergies ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Unknown source
*If yes, please provide a copy of the **Emergency Allergy Plan** to School*
History of Anaphylaxis ❑ No ❑ Yes Epi Pen required ❑ No ❑ Yes

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease:**

Seizures ❑ No ❑ Yes, type:

❑ This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
Explain: ________________________________
Daily Medications (*specify*): ________________________________

This student may: ❑ **participate fully in the school program**
❑ participate in the school program with the following restriction/adaptation: ____________________

This student may: ❑ **participate fully in athletic activities and competitive sports**
❑ participate in athletic activities and competitive sports with the following restriction/adaptation: ____________

❑ Yes ❑ No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
Is this the student's medical home? ❑ Yes ❑ No ❑ I would like to discuss information in this report with the school nurse.

Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap						
IPV/OPV	*	*	*			
MMR						
Measles	*	*				
Mumps	*					
Rubella	*					
HIB	*				Students under age 5	
Hep A						
Hep B	*	*	*			
Varicella	*					
PCV					Pneumococcal conjugate vaccine	
Meningococcal						
HPV						
Flu						
Other						

Disease Hx of above ______________________ (Specify) ______________________ (Date) ______________________ (Confirmed by)

Exemption

Religious _____ **Medical: Permanent** _____ **Temporary** _____ **Date** _____

Recertify Date _________ Recertify Date _________ Recertify Date ________

Immunization Requirements for Newly Enrolled Students at Connecticut Schools

KINDERGARTEN

DTaP: At least 4 doses. The last dose must be given on or after 4th birthday
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
Hib: Children less than 5 yrs of age need 1 dose at 12 months or older Children 5 and older do not need proof of Hib vaccination
Hep B: 3 doses
Varicella: 1 dose on or after the 1st birthday or verification of disease

GRADES 1-6

DTaP /Td/Tdap: At least 4 doses. The last dose must be given on or after 4th birthday
Students who start the series at age 7 or older only need a total of 3 doses
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
Hep B: 3 doses
Varicella: 1 dose on or after the 1st birthday or verification of disease

GRADES 7-12

Td/Tdap: At least 3 doses. The last dose must be given on or after 4th birthday. Students who start the series at age 7 or older only need a total of 3 doses
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
Hep B: 3 doses
Varicella: 1 dose on or after first birthday or verification of disease:
VARICELLA VACCINE: For students <13 years of age, 1 dose given on or after the 1st birthday. For students 13 years of age or older, 2 doses given at least 4 weeks apart
VERIFICATION OF DISEASE: Confirmation in writing by a MD, PA, or APRN that the child has a previous history of disease, based on family or medical history

____

Initial/Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number

PARENT & ATHLETE CONCUSSION INFORMATION SHEET

WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

If an athlete reports one or more symptoms of concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of play the day of the injury. The athlete should only return to play with permission from a health care professional experienced in evaluating for concussion.

DID YOU KNOW?

- Most concussions occur without loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

SYMPTOMS REPORTED BY ATHLETE:

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not "feeling right" or is "feeling down"

SIGNS OBSERVED BY COACHING STAFF:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can't recall events prior to hit or fall
- Can't recall events after hit or fall

[INSERT YOUR LOGO]

"IT'S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON"

CONCUSSION DANGER SIGNS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless, or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously)

WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

1. If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.

2. Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, and playing video games, may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.

3. Remember: Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

WHY SHOULD AN ATHLETE REPORT THEIR SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. They can even be fatal.

____
STUDENT-ATHLETE NAME PRINTED

____
STUDENT-ATHLETE NAME SIGNED

____
DATE

____
PARENT OR GUARDIAN NAME PRINTED

____
PARENT OR GUARDIAN NAME SIGNED

____
DATE

JOIN THE CONVERSATION www.facebook.com/CDCHeadsUp

TO LEARN MORE GO TO >> WWW.CDC.GOV/CONCUSSION

Content Source: CDC's Heads Up Program. Created through a grant to the CDC Foundation from the National Operating Committee on Standards for Athletic Equipment (NOCSAE).

CENTRAL CONNECTICUT COAST YMCA
CONFIDENTIAL
FINANCIAL ASSISTANCE APPLICATION

The Central Connecticut Coast YMCA offers financial assistance for programs to qualified members. We are community based and believe that our programs should be available to everyone and that no one should be turned away because of their inability to pay. Our Financial Assistance Program is made possible because caring people and businesses in our communities fund the program through our Annual Campaign. Financial Assistance is available on a sliding scale that is based on total household income, family size and number of participants for a specific program.

It's easy to apply:

1. Please circle the program for which you would like financial assistance. One program per application.
2. Complete both sides of the application, including name and contact details, household members, and itemized income information. Please include any registration materials for the program(s) for which you are requesting financial assistance.
3. Child Care and Summer Camp applicants must also complete the CT Department of Social Services Care-4-Kids application in order for this application to be processed or reviewed.
4. A copy of your most recent Internal Revenue Service tax statement (tax return) and the last three pay stubs of all working adults must be included to process the application. Your SSI Allocation statement, DSS budget worksheet and any unemployment documents (if applicable) must also be included. Include any other documentation that supports your current income. (This information will be held confidential).
5. If you need assistance completing the application, please work with our Member Service Team.

Program: Child Care Camp Aquatics Youth/Teen Other:____

Have you previously applied for financial assistance at the YMCA? Yes No If yes, which YMCA? __________________________________

Today's Date______________________________

Your Name ____Date of Birth_______________________

Address____

City____State____________Zip Code__________________________

Home Phone_______________________________Work Phone_______________________________Cell Phone______________________________

Place of Current Employment____Length of Employment __________________

Program Participant(s)

Last Name First Name Date of Birth

____

____

____

____

Household Members (List all – adults and youth)

Last Name First Name Date of Birth

____

____

____

____

____

____

____

____

CENTRAL CONNECTICUT COAST YMCA
CONFIDENTIAL FINANCIAL ASSISTANCE APPLICATION page 2

Household Income	Monthly
Wages, Salaries & Tips (all sources in household)	$
Unemployment Compensation	$
Social Security Compensation	$
Disability Compensation	$
Child Support	$
Alimony	$
Aid to Dependent Children	$
Food Stamps	$
Housing Assistance	$
Utility Assistance	$
401K/Retirement	$
	$

If necessary, include documentation of any special expenses, extenuating circumstances, or crisis expense situations of which we should be aware.

Total amount you feel you can pay per month for program fees. $_______________
An amount must be entered or the application will not be processed.

REMEMBER: A copy of the most recent Internal Revenue Service tax statement (tax return) and the last three pay stubs of all working adults must be included for this application to be processed. Your SSI Allocation statement, DSS budget worksheet and any unemployment documents (if applicable) must also be included. You may choose to include your W-2's, and/or any other documentation that supports your current income. (This information will be held confidential). Child Care and Summer Camp applicants must also complete the Department of Social Services Care-4-Kids application and return it with this application in order for this application to be processed or reviewed.

I certify that the above information is true and complete to the best of my knowledge. If requested, I will provide further substantiation of all facts included above. I understand that applications take at least two weeks to process, after which a YMCA representative will contact me. I acknowledge that an incomplete application will not be processed.

Applicant's Name (print)____

Applicant's Signature____

Office Use Only
Date Received:______________________________
Program:______________________________ Date(s) of Program:______________________________
Financial Assistance Awarded (%):______________________

Branch Signature:______________________________ Date Approved:______________________________