Safe Site Educational Center

1800 Main Street NE
Los Lunas, NM 87031
(505)565-8023
contact@safesitenm.com

Enrollment Application

***The following documents must be completed and/or turned in prior to the first day of attendance.

☐Enrollment Packet ☐ Up-to-date Immunization Records ☐ Copy of Social Security Card
☐Billing Form ☐ Income Eligibility Application (IEA) ☐ ASQ/ASQ-SE Consent
☐Health Screening Form ☐ Elementary School that your child is attending: _____

Child's Legal Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

SS#: _____-_____-_____ Gender: ☐Female ☐Male

Father's Full Name: _____ SS#: _____-_____-_____
Address: _____ City: _____ State: _____ Zip: _____
Home #: _____Cell #: _____ Email address: _____
Work Place: _____ Work #: _____ Driver's License #: _____

Mother's Full Name: _____ SS#: _____-_____-_____
Address: _____ City: _____ State: _____ Zip: _____
Home #: _____Cell #: _____ Email address: _____
Work Place: _____ Work #: _____ Driver's License #: _____

Race (check only one): ☐American Indian/Alaskan Native ☐Native Hawaiian or other Pacific Islander
☐Caucasian (White) ☐African American ☐Asian ☐Other _____
Ethnicity: Hispanic or Latino ☐Yes ☐No

Language Spoken at Home: Primary _____ Secondary _____
Bi-lingual ☐ Yes ☐ No What other languages does your child speak? _____

Child's Full Name: _____ Date of Birth: _____

The following persons *are authorized* to pick up my child:

All persons picking up any child must be at least 18 years old and have a picture ID with their date of birth listed.

Name: _____ Driver's License #: _____

Relationship to child: _____ Phone #: _____

Name: _____ Driver's License #: _____

Relationship to child: _____ Phone #: _____

Name: _____ Driver's License #: _____

Relationship to child: _____ Phone #: _____

*** List any person that *cannot* pick up your child:

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Emergency Contacts

Name: _____ Relationship to child: _____

Home #: _____ Cell #: _____ Work #: _____

Name: _____ Relationship to child: _____

Home #: _____ Cell #: _____ Work #: _____

Name: _____ Relationship to child: _____

Home #: _____ Cell #: _____ Work #: _____

Parent/Guardian Signature: _____ **Date:** _____

Allergies and/or Medical Conditions

List any allergies your child has: (foods, medications, etc.)

1. _____ 2. _____ 3. _____

List any medical conditions/health issues your child has:

1. _____ 2. _____

Does your child have any special dietary conditions? ☐**Yes** ☐**No**

If yes, please describe dietary condition(s):

_____

Consent for Emergency Treatment, Permission to Emergency Transport & Hospital Preference

In such a case as necessary, I hereby give my consent for emergency medical treatment and transportation for my child:

Child's Name: _____ Date of Birth: _____

I understand that a conscientious effort will be taken to contact me, but if this is not possible my child may be treated and transported to an emergency care facilty.

Preferred Hospital: _____ Phone #: _____

Physician's Name: _____ Phone #: _____

Parent/Guardian Signature: _____ **Date:** _____

***Safe Site is not responsible for any costs incurred for emergency treatment and/or emergency transportation!

Permission to Leave Facility

I give my permission for my child to be transported to/from school in a Safe Site company owned vehicle. I understand that all staff driving the company owned vehicles have a current and valid NM drivers licence and that the company owned vehicles are fully insured.

Parent/Guardian Signature: _____ **Date:** _____

Photo Consent

I give my consent for pictures to be taken of my child for the purpose of classroom activities, special days, field trips, etc.

Parent/Guardian Signature: _____ **Date:** _____

Rates and Fees Schedule

***Billing is completed on a weekly basis and payment is due the first day of every week unless other arrangements are made with the director. At this time there are no sibling discounts!

Before and After School	$ 60.00 a week	Summer Program	$ 80.00 a week
Full Time	$ 128.63 a week	Part Time	$ 117.90 a week
Hourly (2 hour minimum)	$ 6.00 an hour	After Hours Care	$ 9.00 an hour

Monthly Rate: 5% discount if payment is made on the first day of the month

Transportation Fee $ 30.00 a month This is for transportation to and from school only!

State Funded Child Care Assistance: Co-payments are due by the 15th of the month

I understand the rates, fees and services being offered by Safe Site and I agree to fulfill my financial obligations in accordance with the rate and fees schedule listed above.

Parent/Guardian Signature: _____ **Date:** _____

Acknowledgement

I have read Safe Site's Family Handbook and Discipline Policy and agree to comply with Safe Site's Policies and Procedures. I understand that Safe Site reserves the right to change its policies and procedures with as much notice as possible to families. I have reviewed the rates and fees schedule, along with other services provided by Safe Site and I am willing to abide by the policies/procedures. The staff will make every effort to ensure the safety of my child and I will not hold Safe Site responsible for any injury or accident that may result on or off the child care grounds/facility.

Parent/Guardian Signature: _____ **Date:** _____

New Mexico pre K Invest A Little Get A Lot

FOCUS On Young Children's Learning

New Mexico Early Childhood Education & Care Department

Enrollment Date: _____ Withdrawal Date: _____

Revised 8/2021

BILLING

Child's Name: _____ **Date of Birth:**_____ **Parents Name(print):**_____

Payment Agreement – Must be signed upon registration. *Make selections below, one under Billing Plan and one under Payment Schedule.*

Billing Plans / Payment – Multiple billing plans are available. There is **NO REDUCTION IN RATES** for closed days, holidays or sick days (not applicable to Hourly and Daily billing plans). Any hours over and above allocated hours will be billed at the hourly rate. A two-week notice must be submitted in writing to the Director for any requests to change billing plans, and upon Director approval a new billing/payment agreement will be completed and signed. *Note: for hourly rates, minutes 1-30 are billed at half hour rate, minutes 31-59 are billed at a full hour rate.*

PREFERRED METHOD OF PAYMENT: ☐ **CASH** ☐ **CHECK** ☐ **CREDIT CARD**

Select One Billing Plan	PLAN	COST	NOTES
☐	**Full Time**	$128.63 per week	6 hours or more per day OR 6:00 am to 6:00 pm (5% discount each additional child)
☐	**Part Time**	$117.90 per week	Up to 5 hours per day
☐	**Before & After School / School Age Children**	$60.00 weekly Summer rate $80.00 weekly	Summer rate applies to the months of June, July
☐	**Hourly / Drop In**	$6.00 per hour	2 hours minimum per day
☐	**Daily**	$30.00	5 hours minimum
☐	**State Funded** (CYFD Placement Agreement)	Co-Payment (as determined by CYFD)	Due by the 15th of each month.
☐	**Transportation Fee**	☐ $3.00 each way ☐ OR $30.00 per month	Transportation is for regular school schedules **ONLY.** If your child misses the center school bus there will be a $3.00 transportation fee AND a two-hour minimum hourly rate.

Select One Payment Schedule	PAYMENTS
☐	**Weekly Payments:** Due one (1) week in advance of services rendered and payable every Friday unless alternate arrangements made *in advance and approved by the Director.* Hourly billing plan must give one (1) week deposit and balance to be paid every Friday by 6:00 pm closing (credits/overpayments will be carried to the following week)
☐	**Monthly Payments:** Due 1st Monday of the month. Must be approved by the Director.
☐	**15th of each month: ONLY State Funded** accounts are eligible for this schedule.

LATE & PAST DUE ACCOUNTS: $10.00 LATE FEE will be applied to all past due accounts. After three days past due, account accrues a daily late fee of $3.00 per day in addition to the initial $10.00 late fee. Child care services will not be rendered and your child will not be accepted until past due accounts are paid in full. Multiple/repeated late payments will result in disenrollment. Parent or legal guardian agrees to pay any costs and fees associated with collection efforts (including and not limited to attorney's fees and/or court costs). Accounts with history of past due, late payments, or NSF payments will not be eligible for the Monthly Payment Schedule and must be paid on the Weekly Payment Schedule. **EXPIRED CYFD PLACEMENT AGREEMENT:** Parent or legal guardian will be responsible for charges that accrue on an account with an expired placement agreement (State Funded).

Signature: _____ **Date:** _____

Safe Site Child Development, Inc.
1800 Main Street NE
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Annual Well-Child Check Up
Health Screenings

Child's Name: _____ **Date of Birth:**_____

All children should get an annual well-child check up every year even if they look or feel healthy. The well-child check up helps to prevent illnesses, identify concerns early, monitor development and ensures your child gets needed immunizations.

My child has had a well-child check up in the past 12 months. (including immunizations) ☐Yes ☐No

My child has had a dental screening in the past 12 months. ☐Yes ☐No

My child has had a vision screening in the past 12 months. ☐Yes ☐No

My child has had a hearing screening in the past 12 months. ☐Yes ☐No

I have received and/or been offered a Community Resource List that includes well-child physicians, dentists, vision and hearing providers.

ASQ/ASQ-SE
Consent

The first five years of life are very important for your child because this time sets the stage for success in school and later in life. During infancy and early childhood, your child will gain many experiences and learn many skills. It is important that each child's development proceeds well during this period.

Please check the box that pertains to your child:

☐ I *do* wish to have my child participate in the screening/monitoring program.

☐ I *do not* wish to have my child participate in the screening/monitoring program.

Parent/Guardian Signature: _____ **Date:** _____

FOCUS On Young Children's Learning

NEW MEXICO Early Childhood Education & Care Department

New Mexico pre-K Invest A Little Get A Lot

Revised 7/2021

Child and Adult Care Food Program
INCOME ELIGIBILITY APPLICATION

Name of Facility / Center / Site:	Facility / Center / Site EPICS ID #:	Phone Number:
Safe Site Youth Development, Inc.	0514/164	(505) 565 / 8023

Instructions: Complete this form and return to the Center's Office

ENROLLED PARTICIPANT INFORMATION: (Check if applicable for Enrolled Participant) Case #:

First:	Last:	DOB:		Child Care Centers:		Adult Daycare Centers:			
			☐ Foster Child?	☐ SNAP	☐ FDPIR	☐ SNAP	☐ FDPIR	☐ SSI	☐ MED
			☐ Foster Child?	☐ SNAP	☐ FDPIR	☐ SNAP	☐ FDPIR	☐ SSI	☐ MED
			☐ Foster Child?	☐ SNAP	☐ FDPIR	☐ SNAP	☐ FDPIR	☐ SSI	☐ MED
			☐ Foster Child?	☐ SNAP	☐ FDPIR	☐ SNAP	☐ FDPIR	☐ SSI	☐ MED
			☐ Foster Child?	☐ SNAP	☐ FDPIR	☐ SNAP	☐ FDPIR	☐ SSI	☐ MED

If Enrolled Participant is a Foster Child: Please list the amount of the child's "personal use" monthly income (if no personal income, record "0"): ____________

HOUSEHOLD INFORMATION:

List the first and last name of each person living in the household, related or not (such as grandparents, other relatives, or friends who live in the household). Include yourself and all children over the age of 13 living with you. (Please use additional forms if more lines are required).

First:	Last:	First:	Last:

Total Number in Household: ____________

HOUSEHOLD INCOME: (Please indicate source and amount of current income for all members of your household. Please follow the definition of income specified in the standards for determining free and reduced-price eligibility in your parent letter. If you receive more than one check from any of these sources, please indicate the total ***monthly*** amount received.

Wages / Salary: $ ________ Child Support: $ ________ Social Security: $ ________ Pension/Retirement: $ ________
Unemployment: $ ________ Other Income: $ ________ Total Income: $ ________ ☐ Monthly

PENALTIES FOR MISREPRESENTATION: I certify that all the above information is true and correct and that the food stamp or FDPIR number is correct or that all income is reported. I understand that this information is being given for the receipt of Federal funds; that institution officials may verify the information on the statement and the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

Signature of Adult Family Member ________ Last Four Digits of Social Security Number* ________ ☐ Check if no SS# ________ Date

Privacy Act Statement:

This explains how we will use the information you give us. The Richard B. Russell National School Lunch Act requires that, unless the participant's food stamp or FDPIR number is provided, you must include the social security number of the household member signing the statement or an indication that the household member signing the statement does not possess a social security number. Provision of a social security number is not mandatory, but if a social security number is not provided or an indication is not made that the adult household member signing the statement does not have one, the statement cannot be approved. The social security number may be used to identify the household member in carrying out efforts to verify the correctness of the information on the statement. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a food stamp or FDPIR office to determine current certification for receipt of SNAP (food stamp) or FDPIR benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to verify the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal action if incorrect information is reported.

FOR SPONSOR'S USE ONLY

☒ Child Day Care Center ☐ Adult Day Care Center ☐ Approved Free ☐ Approved Reduced ☐ Paid

Sarah D. Candelaria — Signature of Facility / Center / Site Representative
Safe Site Youth Development, Inc. — Name of Facility / Center / Site Representative
________ Approving Date
________ Date Disenrolled

* Complete Social Security Number is not required for CACFP Participation, only the last four digits are required.

NM FNB CACFP 05/2020