THE YMCA OF KLAMATH FALLS
Fairview Site
1017 Donald Street
Klamath Falls OR 97601
541-887-2512
www.kfallsymca.org

Today's Date_____
Start Date_____

Y Member___ Community___

YMCA PRESCHOOL Registration 2025-2026

Both sides of this form are to be completed by a legal parent or guardian.

Name of Child_____DOB_____Age_____

Child Lives With: Both Parents _____ Mother _____ Father ____ Other _____

Parent/Guardian #1_____ DOB_____

Address _____ City & Zip Code _____

Cell Phone_____ Work Phone_____

Email_____ Employer_____

Employer Address _____

Parent/Guardian #2_____ DOB_____

Address_____ City & Zip Code_____

Cell Phone_____ Work Phone_____

Email_____ Employer_____

Employer Address _____

Emergency Contact and people authorized to pick up child

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

A $25.00 registration fee applies to all programs. Due at time of registration.

PRESCHOOL FULL DAY 7:00 am-5:30 pm

	Y Member	Community
__ Monday-Friday	$930	$1,020
__ Mon/Wed/Fri	$605	$665
__Tues/Thurs	$405	$460

PRESCHOOL HALF DAY 7:00 am-1:00 pm

	Y Member	Community
__ Monday-Friday	$585	$642
__ Mon/Wed/Fri	$405	$575
__Tues/Thurs	$260	$290

Prices subject to change without notice

Preferred Language in the home_____

Name of Family Physician_____Phone_____

Name of Dentist/Orthodontist_____Phone_____

Medical Insurance Carrier _____Policy or Group #_____

Special Arrangements we need to be aware of (visitation, etc.)_____

_____

Allergies_____

Dietary Allergies_____

AGREEMENTS AND RELEASE – Please read & initial each numbered statement.

1. ___My child has permission to participate in The YMCA of Klamath Falls Preschool and Childcare daily activities, including walking field trips, religious or cultural events, such as activities related to holidays.
2. ___I understand that tuition must be **auto drafted**. You can choose the 1st, 5th, 10th or 15th of the month to draft. **A $25.00 returned payment fee will be applied if draft fails.** If payment is not processed by the 15th, suspension from the program may occur if payment in full is not made by the 15th of the current month.
3. ___No credit will be given for sick or missed days. We cannot trade days in order to make up for "lost" time.
4. ___I understand that I must submit a two-week written notice to withdraw my child from this program. I am responsible for all fees accrued in this two-week time period.
5. ___I understand that according to state law, the YMCA is required to report suspected child abuse.
6. ___I give permission to the YMCA for my child to go on supervised field trips in YMCA vehicles. Parents will be notified of anything that requires us to leave YMCA property.
7. ___I understand The YMCA of Klamath Falls programs are not covered by medical, dental, or accident insurance. Each participant must furnish his/her own coverage.
8. ___In case of sickness or accident, if unable to communicate with me, I hereby authorize the YMCA to secure the transportation and medical attention required for my child at my expense.
9. ___To the best of my knowledge, my child is free of potential health problems that might restrict his/her participation. I agree to notify the YMCA immediately if my child is exposed to any communicable disease.
10. ___I understand that the YMCA staff and volunteers are not allowed to transport or babysit my children at any time outside of the YMCA programs.
11. ___I give my permission for YMCA staff to apply sunscreen to my child prior to going outside.
12. ___If my child attends YMCA extracurricular activities (i.e., dance, swimming, yoga, Zumba, fitness-related classes, sports, soccer, volleyball, etc.), I give permission for the YMCA staff to sign my child in/out of their class. I understand that my child will be in a class not run by the Childcare Program and will not be under the Childcare Division Licensing Rules. I understand that during the time my child is signed out of the Childcare Program, he/she is under the rules and regulations set forth by The YMCA of Klamath Falls. All YMCA staff have undergone background checks.
13. ___I hereby grant The YMCA of Klamath Falls the right to use pictures/photographs/videos of my child for display or advertising specifically for YMCA programs.
14. ___I have viewed, understand and agree to abide by the policies outlined in the YMCA Parent Handbook.
15. ___I understand that my child needs to be picked up at the end of the day by 5:30. If I cannot be there by 5:30 pm, I understand that I must contact the office with alternative arrangements. A late pick-up fee of $20.00 will be charged for every 15 minutes starting at 5:31 pm.
16. ___I have viewed the Certificate of Approval from the Office of Childcare located on the parent boards throughout the facility.
17. ___ No refunds or credit will be given for unforeseen closures due to weather, illness, etc.

Signature of Parent/Guardian_____Date_____

OMER Roster Number ________

Child and Adult Care Food Program CHILD ENROLLMENT FORM

Child Care Centers/Head Start Programs

The YMCA of Klamath Falls

CACFP Sponsor Name/Site Name

TO BE COMPLETED BY PARENT/GUARDIAN ONLY

The CACFP reimburses centers for serving nutritious, well-balanced meals and snacks to children in care. Complete the following chart for all children in care. Sign, date, and return to the center. Use additional forms, as needed. Parents/guardians of all infants must complete the Infant Formula Selection section.

Children's Names	Normal Hours in Care: Enter the time your child usually *arrives* each day.	Normal Hours in Care: Enter the time your child usually *leaves* each day.	Normal Meals and Normal Days in Care
Last: First	____ Time ☐ AM ☐ PM	____ Time ☐ AM ☐ PM	**Normal Meals While In Care** ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack **Normal Days of the Week in Attendance** ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun
Last First	____ Time ☐ AM ☐ PM	____ Time ☐ AM ☐ PM	**Normal Meals While In Care** ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack **Normal Days of the Week in Attendance** ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun
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Last First	____ Time ☐ AM ☐ PM	____ Time ☐ AM ☐ PM	**Normal Meals While In Care** ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack **Normal Days of the Week in Attendance** ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun

Parent/Guardian Print Name: ______________________________ Date ________

Parent/Guardian Signature: ______________________________

INFANT FORMULA SELECTION: Complete if any child listed above is an infant under one year of age

This center provides ______________________________ (list brand) iron fortified infant formula.

Check one:
- ☐ I accept the center provided formula
- ☐ I decline the center provided formula

I understand that by declining the center provided formula, I agree to provide breast milk or formula for my child. If I provide formula it must be on the approved formula list for the center to be reimbursed for the meal.

Updates: *(annual at a minimum)*	The parent/guardian signing this form certifies that the enrollment information is correct. If information has changed, the parent/guardian has written the appropriate changes on the form and initialed the change. *If there are many changes, please complete a new form.*	
First Update	*Parent/Guardian Signature*	*Date*
Second Update	*Parent/Guardian Signature*	*Date*
Third Update	*Parent/Guardian Signature*	*Date*
Fourth Update	*Parent/Guardian Signature*	*Date*

This institution is an equal opportunity provider.

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled at a child care center. **The YMCA of Klamath Falls** offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached Confidential Income Statement. In addition, by filling out this form, we will be able to determine if your child(ren) qualifies for free or reduced price meals.

1. **Do I need to fill out a Confidential Income Statement for each of my children in day care?** Complete and submit one CACFP Confidential Income Statement for all children in your household **only** if they are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. **Return the completed form to: The YMCA of Klamath Falls, 1017 Donald Street, Klamath Falls, OR 97601.**

2. **Who is eligible for free meals without providing income information?** Children in households getting Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) are eligible for free meals. Foster children and children enrolled in Head Start based on income are also eligible for free meals. Children in households participating in WIC may be eligible for free meals.

3. **Who can get reduced price meals?** Your children can get low-cost meals if your household income is within the reduced price limits on the Federal Income Guidelines shown on this application. Children in households participating in WIC may be eligible for reduced price meals.

4. **May I fill out a form if someone in my household is not a U.S. citizen?** Yes. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the center or the day care home.

5. **Who should I include as members of my household?** You must include all people in your household (such as grandparents, other relatives, or friends who live with you) who shares income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you.

6. **How do I report income information and changes in employment status?** The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Federal Income Guidelines, the family day care home or center will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or providing a current SNAP, TANF, FDPIR case number, you will remain eligible for those benefits for a period not to exceed 12 months. You should, however, notify us if you or someone in your household becomes unemployed and the loss of income during the period of unemployment causes your household income to be within the eligibility guidelines.

7. **What if my income is not always the same?** List the amount that you normally earn. For example, if you normally earn $1000 each month, but you missed some work last month and only earned $900, put down that you earn $1000 per month. If you normally earn overtime, include it, but not if you only earn it sometimes.

8. **What if I have foster child(ren)?** Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the confidential Income Statement, but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children should contact **The YMCA of Klamath Falls, 1017 Donald Street, Klamath Falls, OR 97601.**

9. **We are in the military; do we include our housing and supplemental allowances as income?** If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

10. **Centers charging for meals only (Pricing programs only). Will the information I provide be verified?** Maybe. We may ask you to send written proof to verify the information you submitted on the form. **What if I disagree with the decision about the information I complete on this form?** You should talk to your sponsoring organization. You may ask for a hearing by calling or writing to: **USDA (503)887-2512.**

In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex, age or disability.

If you have other questions or need help, call **541-887-2512.**

Sincerely,

The YMCA of Klamath Falls

This institution is an equal opportunity provider.

OMER Roster Number _____

2025-2026 CONFIDENTIAL INCOME STATEMENT – Child Care Centers/Family Day Care Providers

INSTRUCTIONS:

- If your household received SNAP, TANF or FDPIR, complete parts 1-3, and 5; part 6 is optional.
- If you do not receive these benefits and your income is <u>below</u> the guidelines (back) complete parts 1, 2, 4, and 5; part 6 is optional.
- If you are applying for a FOSTER CHILD only, complete parts 1, 2, and 5; part 6 is optional.

Any income fields left blank will be counted as zeros. Please be careful that you meant to leave income fields blank.

1 HOUSEHOLD INFORMATION

Print name of person completing this application (Last name, First name)

Name Print

Mailing Address – Apt #

City State Zip

Home Phone or Cell Phone (Circle One)

Work Phone

→ Number living in this household _____
(Write names of **all** household members on part 2 and/or part 4 of this form)

2 CHILD INFORMATION – (Names of Your Children *Enrolled* in Child Care)

Child's Name (Legal Last name, First name)	Birth Date	Age	Check if Foster Child (placed by welfare agency or court) If only foster care child(ren) see instructions above
1.			☐
2.			☐
3.			☐

3 PUBLIC BENEFITS Indicate which **benefits** your household currently receives, and list case number, if any:

Name: _____ Case Number: _____

- ☐ SNAP (Supplemental Nutrition Assistance Program) (*Oregon Trail Card number not acceptable*)
- ☐ TANF (Temporary Assistance to Needy Families) (*Employment Related Day Care does not qualify*)
- ☐ FDPIR (Food Distribution on Indian Reservations)

4 HOUSEHOLD MEMBERS & GROSS MONTHLY INCOME – if not monthly, see back for conversions

	Column 1 List **all** household members, including children not attending school, and income. Do not include children listed in part 2, unless they receive regular income. (*Last name, first name*)	Column 2 MONTHLY INCOME (Total earnings & wages before deductions)	Column 3 MONTHLY CHILD SUPPORT, WELFARE, ALIMONY RECEIVED	Column 4 MONTHLY PENSIONS, SOCIAL SEC., RETIREMENT, SSI, VA	Column 5 OTHER MONTHLY INCOME -Including unemployment and workers comp.	Column 6 Check if No Income
1.						☐
2.						☐
3.						☐
4.						☐
5.						☐
6.						☐
7.						☐

5 SIGNATURE, DATE and Last four numbers of SOCIAL SECURITY NUMBER (Adult must sign)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Signature of Adult Household Member

X _____

Date Signed

_____
Month/day/year

Social Security Number
(See privacy statement on back)

XXX-XX - __ __ __ __

☐ **I do not have a Social Security Number.**

6 RACIAL OR ETHNIC GROUP (OPTIONAL)

<u>Mark one ethnic identity:</u>

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

<u>Mark one or more racial identities:</u>

- ☐ Asian
- ☐ American Indian & Alaskan Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Black or African American
- ☐ White
- ☐ Other

SPONSOR USE ONLY - DO NOT WRITE BELOW THIS LINE

Total Income: _____ Number in Household: _____

<u>Centers</u>

Eligibility : ☐Free ☐Reduced Price ☐Above Scale

<u>FDCH</u>

☐Tier 1 ☐Tier 2

Eligibility based on : ☐SNAP ☐TANF ☐ FDPIR ☐Household Income ☐ Foster Child

Notes: _____

Determining Official's Signature : _____

Date _____

Second Check Signature: _____ Date _____

SEE IMPORTANT INFORMATION ON REVERSE SIDE

DETERMINING MONTHLY INCOME FOR EARNINGS & WAGES

Monthly income for all household members must be reported in Section 4 of this application. Income means any money regularly received from work, child support, alimony, pensions, retirements, social security or any other source. Exclude student/scho ol loans. Money received from a business or farm owned by you should be reported as "net income". *Net Income is defined as the total income left after business and farm operating expenses are subtracted from gross receipts.*

Homeless, migrant and runaway youth are categorically eligible for free meals.

Household members who are not paid monthly should change earnings into monthly income by doing the following:

Household members who are paid every week: Multiply total earnings and wages for one pay period, before deductions, by 52. Then divide by 12. The resulting amount is the total monthly income.

Household members who are paid every 2 weeks: Multiply total earnings and wages for one pay period, before deductions, by 26. Then divide by 12. The resulting amount is the total monthly income.

Household members who are paid twice a month: Multiply total earnings and wages for one pay period, before deductions, by 24 then divide by 12. The resulting amount is the total monthly income.

Household members who are seasonal workers or work less than 12 months: Project annual rate of income to accurately represent actual circumstances then divide by 12. The resulting amount is the projected monthly income.

FEDERAL INCOME GUIDELINES

Participants may qualify at least for reduced price meals if your household income falls within the limits of this chart.

	Reduced Price Meals				
Household Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
-1-	28,953	2,413	1,207	1,114	557
-2-	39,128	3,261	1,631	1,505	753
-3-	49,303	4,109	2,055	1,897	949
-4-	59,478	4,957	2,479	2,288	1,144
-5-	69,653	5,805	2,903	2,679	1,340
-6-	79,828	6,653	3,327	3,071	1,536
-7-	90,003	7,501	3,751	3,462	1,731
-8-	100,178	8,349	4,175	3,853	1,927
For each additional family member add	10,175	848	424	392	196

PRIVACY STATEMENT - SOCIAL SECURITY NUMBERS and OTHER INFORMATION

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the in formation but if you do not, we cannot approve your child for free or reduced price meals. You must include the last 4 digits of th e social security number of the adult household member who signs the application. The last 4 digits of the social security number is not requir ed when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program case number or Food Distribution Program on Indian Reservations (FDPIR) identifier for your child or when you indicate that the adult household member signing the application does not have a social securi ty number. We will use your information to determine if your child is eligible for free or reduced price meals and for administration and enforcement of the lunch and breakfast programs. We **may** share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs; auditors for program reviews; and law enforcement officials to help them look into violations of program rules. We may share the information on this form with Medicaid, unless you tell us not to. The information, if disclosed, will only be used to identify eligible participants and seek to enroll them in Medicaid.

NON-DISCRIMINATION 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., Braill e, 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/oascr/how-to-file-a-program-discrimination-complaint, 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 **fax:** (833) 256-1665 or (202) 690-7442; or **email:** program.intake@usda.gov. This institution is an equal opportunity provider.

YMCA Individual Plan of Care for a Child With Special Health Care Needs or Disabilities

Child's Name_____ Date of Birth ___/___/___

An individual plan of care is necessary when a child has a special health care need or disability, and it is necessary that special care be taken or provided while the child is at the childcare program.

Special health care need or disability:

Special care needed:

Other relevant information:

Signature(s) of the Parent(s): Date Signed:

_____ ___/___/___

_____ ___/___/___

4144-300-0040-(4)(h) requires any chronic health problems the child has, including allergies.

Name: _____ **Membership #:** _____

AUTO-DRAFT AUTHORIZATION FORM FOR CHILDCARE ONLY

THE YMCA OF KLAMATH FALLS

READ AND INITIAL EACH SECTION BEFORE SIGNING

	I authorize my financial institution to honor pre-authorized auto-drafts by The YMCA of Klamath Falls on my account for my **Childcare** payments. It is understood that my **Auto-Draft will be continuous until I submit written notice.** When my financial institution honors the draft by charging my account, such drafts constitute my receipt for payment.
	I understand that the draft will continue until my account is at a $0.00 balance for the current Childcare School Year or I give the Billing Director written notice. Written notice may be given in the form of an email or letter. If at any time there is to be a change or cancellation of payment plan, written notice is to be submitted to The YMCA of Klamath Falls at Fairview, or emailed to the Billing Director one (1) calendar week prior to the day of the next auto-draft. Failure to do so will make the subsequent draft **non-refundable.**
	I must **choose either the 1st, 5th, 10th, or 15th to be draft** and this will continue until my account is at a $0.00 balance or written notice is given. (Some banking institutions will run a pre-note trial on the first of the month in the amount of $00.00 to verify that all the banking information is correct.)
	I agree that if my auto-draft from a checking, savings or credit card account is returned unpaid, for any reason, the YMCA will automatically redraft the account for the balance due and also apply a **$25.00 returned bank draft fee.** Your signature below is your agreement to these terms.
	If the YMCA initiates an erroneous entry to my account, I shall have the right to a refund by check within 30 calendar days following notification and proof of error.
	Changes or cancellations must by in writing.
	A voided check from my checking account, complete savings account information with both the routing number and account number, or credit card account information is required to complete all auto-draft applications.

PREFERRED DATE OF AUTO-DRAFT (Please circle date here.) **1st** **5th** **10th** **15th**

Monthly DRAFT AMOUNT will be current monthly cost of childcare program.

$ _____ Beginning Date _____

By signing here, I agree to all of the above conditions and terms.

Signature of Account Holder _____ **Date** _____

Attach voided check here

OR

Write complete checking or savings account information below.

Checking routing # _____ Account # _____

Savings routing # _____ Account # _____

OR

Write complete credit/debit card account information below.

Visa, MC, Etc. _____ Card # _____ Exp _____

Security code from back of card _____

Exact name on card _____