25-26 Pre-K Required Documents

Required Document	Date Received	Admin Signature
Pre-K Registration Form		
Parental Agreement Form		
Original Birth Certificate		
Proof of Georgia Residency (Mortgage or Lease/Rental Agreement, Gas, or Water Bill)		
Child's Original Social Security Card		
Copy of Peach Care Card, Health Insurance Card, Food Stamp Card, or TANF (If applicable)	Date _____ Yes _____ No _____	
Current Immunization Certificate (Form 3231)	Exp Date _____	
Vision, Hearing, Dental Screening Certificate (Form 3300)	Exp _____ Exp _____ Exp _____	
GA Pre-K Roster		
CACFP Meal Benefit Income Eligibility Statement		

Georgia Dept of Early Care and Learning
BRIGHT FROM THE START

Please write the school year in the box →

Pre-K Registration Form

_____ School Year

PROVIDER LEGAL NAME:	(This section to be completed by the provider)
SCHOOL/SITE NAME:	

CHILD INFORMATION	**(Please print name exactly as it appears on the birth certificate.)**		
CHILD'S LAST NAME: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |			
CHILD'S FIRST NAME: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |			
CHILD'S MIDDLE NAME: | | | | | | | | | | | | | | | | | | NAME SUFFIX:| | | | (i.e. Jr, Sr, II,III)			
CHILD'S SOCIAL SECURITY#:	D.O.B. (MM/DD/BY):	SEX: [ ]M [ ]F	
HOME ADDRESS (*Do not enter PO Box Info*):		COUNTY:	
CITY:	STATE: GA	ZIP:	HOME PHONE: ( )

If the Student is transferring from another Pre-K, please provide the following:
Previous School Name: _____ Last Date in Attendance: _____

PARENT/GUARDIAN INFORMATION			
Parent/Guardian #1 - LAST NAME:	FIRST:		MIDDLE INITIAL:
Home Address *(If different from child)*:			
City:	State:	Zip:	
Home Phone: ( )		Cell Phone: ( )	
Email Address:			
Place of Employment:		Work Phone: ( )	
Address:			
City:	State:	Zip:	
Parent/Guardian #2 - LAST NAME:	FIRST:		MIDDLE INITIAL:
Home Address *(If different from child)*:			
City:	State:	Zip:	
Home Phone: ( )		Cell Phone: ( )	
Email Address:			
Place of Employment:		Work Phone: ( )	
Address:			
City:	State:	Zip:	

EMERGENCY CONTACT INFORMATION (Persons to contact in the event that either parent/guardian cannot be contacted)				
NAME	RELATIONSHIP	CELL PHONE	ALTERNATE PHONE	EMAIL
1.				
2.				

I verify the above information to be correct, and I understand that completion of this form does not guarantee placement in a Pre-K class. If my child is placed in Georgia's Pre-K Program, I agree that my child will attend the program for the required number of hours and days as prescribed by the Georgia Department of Early Care and Learning and outlined by the center where my child is enrolled. I understand that failure to comply with these attendance requirements could result in disenrollment. I understand that I cannot register my child without appropriate age documentation. I have attached a copy of appropriate age documentation to this registration form.

Signature Parent/Guardian: _____ **DATE:** _____

CHILD MAINTENANCE

CHILD'S LIVING ARRANGEMENTS: [ ]BOTH PARENTS [ ]MOTHER [ ]FATHER [ ]OTHER

CHILD'S LEGAL GUARDIAN: [ ]BOTH PARENTS [ ]MOTHER [ ]FATHER [ ]OTHER

THE CHILD MAY BE RELEASED TO THE PERSON(S) SIGNING THIS AGREEMENT OR TO THE FOLLOWING:

NAME	ADDRESS	RELATIONSHIP	CELL PHONE
1.			
2.			
3.			
4.			

CHILD'S PHYSICIAN OR CLINIC'S NAME (CHILD'S PRIMARY HEALTH SOURCE): _____.

DATE OF LAST FULL HEALTH SCREENING:_____ PHONE: ( )

MY CHILD HAS THE FOLLOWING SPECIAL NEED(S):

THE FOLLOWING SPECIAL ACCOMMODATION(S) MAY BE REQUIRED TO MOST EFFECTIVELY MEET MY CHILD'S NEEDS WHILE AT THIS CENTER:

MY CHILD IS CURRENTLY ON MEDICATION(S) PRESCRIBED FOR LONG-TERM CONTINUOUS USE AND/OR HAS THE FOLLOWING PRE-EXISTING ALLERGIES, ILLNESS, OR HEALTH CONCERNS:

GENERAL RELEASE

I verify the above information to be correct and true. I hereby grant permission for the information provided in the preceding Registration Form to be distributed to Pre-K providers, the Department of Early Care and Learning (DECAL), and certain agencies or those entities contracted by Pre-K providers or DECAL which shall include, but not be limited to, the Georgia Department of Education, and colleges/universities.

SIGNATURE (Parent/Guardian): _____

DATE: _____

PHOTOGRAPH/VIDEOTAPE RELEASE

I hereby grant permission for the Pre-K provider specified below, the Georgia Department of Early Care and Learning (DECAL) and certain agencies or entities contracted by the Pre-K provider or DECAL which shall include, but not be limited to, the Georgia Department of Education, and colleges/universities, to record the participation and appearance of my child, _____, by photograph and/or videotape in connection with daily Pre-K activities for the purposes of news releases, reporting, and assessing the progress of children and the program. DECAL and its contractors are authorized to exhibit or distribute such photograph(s) and/or videotape in whole or in part without restrictions or limitations for any educational or promotional purpose that DECAL deems appropriate. Such photograph(s) and/or videotape may, for example, appear in printed or visual materials for DECAL and/or on DECAL's web site.

The undersigned hereby jointly and severally releases, acquits, forgives, and discharges the Pre-K provider, DECAL, and other entities contracted by the Pre-K provider or DECAL, from any actions, agreements, claims, controversies, demands, judgments, liabilities, proceedings, and suits, whether arising in equity or in law regarding such participation and appearance by said child.

This release shall remain binding upon all successors in interest and personal representatives of the parties, to the extent permitted by law.

PRE-K PROVIDER NAME/ADDRESS: _____

SIGNATURE (Parent/Guardian): _____

DATE: _____

Trinity AME Early Learning Center LLC
604 Lynhurst Drive SW, Atlanta, GA 30311
404-696-3490
Rev. Charles Ramsey, Board Chairperson
Mr. Thomas Ford, Executive Director

Parental Agreement with Trinity AME Early Learning Center, LLC

Trinity AME Early Learning Center agrees to provide care for _____ (Child's Name) on: **Monday, Tuesday, Wednesday, Thursday and Friday**. The care will be provided from _____ A.M. to _____ P.M.
My child will participate in the following meal plan:
Breakfast, Lunch, and an Afternoon Snack.

Before any medication is dispensed to my child, I will provide a written authorization which indicates dates, name of child, name of medication, prescription number, dosages, and the time the medication should be administered. Medicine must be in the original package with your child's name on it.

My child will not be allowed to enter or leave the facility without being escorted by the parent(s), person authorized by parent(s), or facility personnel.

I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, e.g., telephone numbers, work location, emergency contact, child's physician, child's health status, infant feeding plan and immunization records, etc.

The facility agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, etc., which include my child.

Trinity AME Early Learning Center, LLC agrees to obtain written authorization from me before my child participates in routine transportation for field trips/special activities that are away from the facility. Trinity AME Early Learning Center, LLC agrees to obtain written authorization for my child to participate in water-related activities occurring in water that is more than two feet deep.

I authorize Trinity AME Early Learning Center, LLC to obtain emergency medical care for my child when I am not available.

I have received a copy and agree to abide by the policies and procedures for Trinity AME Early Learning Center, LLC.

I understand that the facility will advise me of my child's progress and issues pertaining to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is encouraged in activities at Trinity AME Early Learning Center, LLC.

Signature: _____ **Date:** _____
(Parent/Guardian)
Signature: _____ **Date:** _____
(Facility Administrator)

Trinity AME Early Learning Center LLC
604 Lynhurst Drive SW, Atlanta, GA 30311
404-696-3490
Rev. Charles Ramsey, Board Chairperson
Mr. Thomas Ford, Executive Director

Vehicle Emergency Medical Information

Child's Name: _____ DOB: _____

Address: _____

Father's Name: _____

Cell Phone: _____ Work Phone: _____

Mother's Name: _____

Cell Phone: _____ Work Phone: _____

Person to notify in an emergency and parents cannot be reached:
Name: _____ Phone #: _____

Child's Doctor: _____ Phone #: _____

Medical Facility: _____

Address: _____

Child's Allergies: _____

Current Prescribed Medication: _____

_____

Child's Special Needs/Conditions: _____

_____

In the event of an emergency involving my child, and if **Trinity AME Early Learning Center, LLC** cannot get in touch with me, I hereby authorize any needed medical care. I further agree to be fully responsible for all medical expenses incurred during the treatment of my child.

Child's Name: _____

Signature (Parent/Guardian): _____

Witnessed By: _____ Date: _____

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Authorization to Dispense External Preparations

I give Trinity AME Early Learning Center, LLC permission to apply one or more of the following topical ointments/preparations/over the counter medications to _____ (Child's Name) in accordance with the directions on the label of the container.

____ Baby Wipes
____ Band-aids
____ Neosporin or Similar Ointment
____ Bactine or Similar First Aid Spray
____ Insect Repellent
____ Non-Prescription Ointment (Such as A&D, Desitin, Vaseline)
____ Baby Powder

Other (Please Specify):
_____

Signature (Parent/Guardian): _____

Date: _____

* Trinity AME Early Learning Center, LLC will maintain a copy of this for the child's records.

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EMERGENCY MEDICAL AUTHORIZATION

Should (Child's Name) _____ suffer an injury or illness while in the care of (Facility Name) ____Trinity AME Early Learning Center_and the facility is unable to contact me (us) immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. I (We) shall assume responsibility for payment for services.

Parent/Guardian (Print Name): _____

Date: _____

Facility Administrator (Print Name): _____

Date: _____

Georgia Department of Public Health
Form 3300

Certificate of Vision, Hearing, Dental, and Nutrition Screening

FILE THIS FORM WITH THE SCHOOL WHEN YOUR CHILD IS FIRST ENROLLED IN A GEORGIA PUBLIC SCHOOL
SCREENER CONTACT INFORMATION IS REQUIRED

PLEASE SEE THE INSTRUCTIONS ON THE BACK OF THIS FORM

Parent/ Guardian Name:_____
first middle last

Parent/ Guardian Contact Information:

Daytime phone number:_____

Evening phone number:_____

Cell phone number:_____

Child's Name:_____
first middle last

Date of Birth: ____/____/____ **Gender:** ☐Male ☐Female

Child's Home Address:

_____
street city state zip code county

VISION

☐ Unable to screen (explain why below)
☐ Uses corrective lenses
☐ Worn for testing

☐ Passed (20/30 in each eye for age 6 and above, 20/40 in each eye for below age 6)
☐ Needs further evaluation
☐ Under professional care (explain below)

Screening completed by:
☐ Physician
☐ Local Health Department
☐ Optometrist
☐ "Prevent Blindness Georgia" employee
☐ School Registered Nurse

_____
Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

HEARING

☐ Unable to screen (explain why below)
☐ Uses hearing aid / assistive device

☐ Passed at 500, 1000, 2000, and 4000 Hz with audiometer at 20 or 25 dB
☐ Needs further evaluation
☐ Under professional care (explain below)

Screening completed by:
☐ Physician
☐ Local Health Department
☐ Audiologist
☐ Speech-Language Pathologist
☐ School Registered Nurse

_____
Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

DENTAL

☐ Unable to screen (explain why below)

☐ Normal appearance
☐ Needs further evaluation
☐ Emergency problem observed
☐ Under professional care (explain below)

Screening completed by:
☐ Physician
☐ Dentist
☐ Local Health Department Registered Nurse
☐ Registered Dental Hygienist
☐ School Registered Nurse

_____
Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

NUTRITION

☐ Unable to screen (explain why below)

Height: _____ Weight: _____

BMI: _____ BMI%: _____

☐ 5th to 84th percentile - Appropriate for age
☐ < 5th percentile - Needs further evaluation
☐ ≥ 85th percentile - Needs further evaluation
☐ Under professional care (explain below)

Screening completed by:
☐ Physician
☐ Local Health Department
☐ Registered Dietician
☐ School Registered Nurse

_____
Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

FOR SCHOOL SYSTEM ONLY Follow up for further evaluation

	1st attempt	2nd attempt	Actions reported (if any)
Vision			
Hearing			
Dental			
Nutrition			

Student support services initiated on:

Screeners' Comments:

DPH Form 3300 Rev. 2013

Georgia Department of Public Health Form 3300

Certificate of Vision, Hearing, Dental, and Nutrition Screening

Who is required to file this Form 3300? The parent or guardian of a child who is being admitted for the first time to a public school in Georgia must file a completed Form 3300 with the school when the child is enrolled.

What is the purpose of Form 3300? Form 3300 is intended to make sure that every child in Georgia is screened for possible problems with their vision, hearing, teeth and nutrition. The earlier these problems are detected, the earlier parents can seek professional help for the child.

What screenings are required? Four different screenings are required: vision, hearing, dental, and nutrition. All four screenings must be conducted and reported on the form before it can be filed with the school.

Who can conduct the screenings? Your child's doctor is authorized to conduct all four screenings, as is your local health department. In addition, the vision screening can be conducted by a Georgia licensed optometrist, an employee of Prevent Blindness Georgia trained to conduct vision screening, or a school registered nurse; the hearing screening can be conducted by a Georgia licensed speech-language pathologist or audiologist, or a school registered nurse; the dental screening can be conducted by a Georgia licensed dentist, dental hygienist, or a school registered nurse; and the nutrition screening can be conducted by a Georgia licensed dietician or a school registered nurse. It is not necessary that the same person conduct all four screenings.

What does "BMI" and "BMI%" mean? "BMI" means "body mass index." BMI is a way to describe how much a child weighs in relation to height. "BMI percentile" is a way to compare the child's body mass index to the body mass index of a healthy child. If the child's BMI is less than 5% or more than 84% of what is appropriate for his or her age and height, then the child should be taken to a doctor or dietician for a more detailed evaluation. For more information, visit the Centers for Disease Control and Prevention website on child and teen BMI at:

http://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html

What should a parent do if the "needs further evaluation" box is checked? "Needs further evaluation" means that the child may have a problem. If the "needs further evaluation" box is checked, then the parent should take the child to a professional for a more detailed evaluation. Your doctor or local health department may be able to help, or recommend someone who can help.

What if a Form 3300 was previously filed for the child at another school? It is only necessary to file the Form 3300 once. If the Form 3300 is filed at the child's first school, and the child later transfers to another school, then the original school is required to forward the Form 3300 to the new school.

Georgia Dept of Early Care and Learning
BRIGHT FROM THE START

Georgia's Pre-K Program Roster Information Form

This form is to be completed after school starts, not at the time of registration. **Please clearly print** the name as it appears on the birth certificate.

TODAY'S DATE (M/D/Y): ____/____/____		
CHILD INFORMATION:		
Legal First Name:		Name Suffix (Jr,II,III):
Legal Middle Name:		Name Child is Called:
Legal Last Name:		
Child's Social Security # ____-____-____	DOB (M/D/Y): ____/____/____	Gender: M ☐ F ☐
Choose Not to Provide SSN ☐	Date enrolled in Pre-K (M/D/Y): ____/____/____	
PARENT/GUARDIAN INFORMATION:		
Last Name:	First Name:	
Relationship: Mother ☐ Father ☐	Grandparent ☐ Guardian ☐	Other ☐
Email Address:	Zip Code:	

1. Identify your child's ethnicity, regardless of race, by selecting one of the below options.

☐ **Hispanic/Latino** ☐ **Not Hispanic/Latino**

☐ **Decline to Answer**

Select **ONE OR MORE** of the following races regardless of how you answered question one.

2. Is your child:

☐ a. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ b. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ c. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ d. **Black or African American** – A person having origins in any of the Black racial groups of Africa.

☐ e. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North and South America including Central America, who maintains a tribal affiliation or community attachment.

☐ f. **Decline to Answer**

3. What is your child's primary language?

☐ **English**

☐ **A language other than English**

3.a. Which language is spoken in the child's home (other than English? _____

4. Was your child born as a:

☐ **Single Birth (1)**

☐ **Twin (2)**

☐ **Triplet (3)**

☐ **Quadruplet (4)**

☐ **Quintuplet (5)**

5. Does your child receive Special Education Services?

☐ **Yes** ☐ **No**

5.a. If Yes, indicate which of the following Special Education Services your child receives.

☐ **Individual Education Program (IEP) (Part B, Section 619, IDEA)**

☐ **504 Plan/Individual Accommodation Plan (IAP) (Section 504 of the Rehabilitation Act of 1973)**

6. Does your child receive any of the following services?

☐ **Childcare and Parent Services (CAPS)**

☐ **Child and Adult Care Food Program (CACFP)**

☐ **Supplemental Security Income (SSI)**

☐ **Supplemental Nutrition Assistance Program (SNAP)**

☐ **Medicaid**

☐ **Temporary Assistance for Needy Families (TANF)**

☐ **Foster Care**

7. Will the Pre-K center be providing transportation for your child?

☐ **Yes** ☐ **No**

_____

Parent/Guardian Signature **Date**

Bright from the Start: Georgia Department of Early Care and Learning

CACFP Meal Benefit Income Eligibility Statement*

PART I: Child(ren) or Adult enrolled to receive day care

Name: (Last, First and Middle Initial)	SNAP, TANF, or FDPIR case number, or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. Note: Do not use EBT numbers. Write case number and proceed to Part III.	Children in Head Start, foster care and children who meet the definition of migrant, runaway, or homeless are eligible for free meals. Check (✓) all that apply. (See definitions in FAQs)				
		Head Start	Foster Child	Migrant	Runaway	Homeless
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐

PART II: Report income for ALL Household Members (Skip this step if participant is categorically eligible as documented in Part I.)

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

A. Child Income[1] - Sometimes children in the household earn or receive income. Please indicate the TOTAL income received by child household members listed in PART I here. Child Income/How often? (i.e., weekly, monthly, etc.) $_____/_____

B. Other Household Members[1]. List all household members even if they do not receive income. Also, list the adult participant if he/she did not meet eligibility in Part I. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only along the frequency i.e., twice a month, weekly, etc. If they do not receive income from any source, write '0'. If you enter "0" or leave any field blank you are certifying (promising) there is no income to report.

Name of Other Household Members (First and Last)	1. Earnings from work before deductions / How often?	2. Subsidies, child support, alimony / How often?	3. Social Security, pensions, retirement / How often?	4. All other income / How often?
1. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____
2. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____
3. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____
4. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____
5. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____

C. Total Household Members (Adults and Children) listed in Part I and Part II _____

Social Security Number. If Part II B is completed and household members are listed (with or without income), the adult completing the form must also list the last four digits of his or her Social Security Number or check the "I don't have a Social Security Number" box below. (See Privacy Act Statement on next page). Failure to complete this section, if income is listed, will result in the denial of free or reduced eligibility.

Last four Digits of Social Security Number XXX-XX_____ ☐ I do not have a Social Security Number

PART III: Enrollment Information: *Children Only*

My child is normally in attendance at the facility between the hours of _____ [am/pm] to _____ [am/pm]. ☐ (✓) Check here if only before/after school care is provided.

Circle the days your child will normally attend the center: **Sunday Monday Tuesday Wednesday Thursday Friday Saturday**

Circle the meals your child will normally receive while in care: **Breakfast AM Snack Lunch PM Snack Supper Evening Snack**

PART IV: Signature

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 purposefully give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted. This signature also acknowledges that the child(ren) or adult listed on the form in Part I are enrolled for care. If not completed fully and signed, the participant will be placed in the Paid category.

Signature: X _____ **Print Name:** _____ **Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

*This application is a revision of USDA's newly released meal benefit prototype and meets all legal requirements and reflect design best practices identified by USDA through focus testing and other research.

PART V: Participant's Ethnic and Racial Identities: *The use of racial and ethnic data is to ensure compliance with USDA nondiscrimination requirements only. Providing information in Part V is voluntary. Your response or lack of response will not impact the participant's eligibility for meals.*

Check (✓) one ethnic identity: ☐ Hispanic/ Latino ☐ Not Hispanic/ Latino

Check (✓) one or more racial identities: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hawaiian or other Pacific Islander ☐ White ☐ Multiracial

Official Use Only Section for Provider: Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12

Total income: _____ Per: ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Year **Household Size:** _____

Categorical Eligibility: check (✓) if applicable ☐ **Eligibility:** check (✓) one Free ☐ Reduced ☐ Paid ☐

Day Care Homes Only: check (✓) one Tier I ☐ Tier II ☐

When more than one person is performing CACFP duties, there must be at least two signatures on this form: one signature from the Determining Official (the official who determined initial income classification) and one signature from the Confirming Official (the official who verified the form's accuracy).

Determining Official's Signature: _____ **Date:** _____

Confirming Official's Signature: _____ **Date:** _____

Follow Up Official's Signature: _____ **Date:** _____

Trinity AME Early Learning Center, LLC

Parent Tuition Agreement Form

Tuition/Fees are as follows:

Annual Registration Fee (Infant, Toddler and Preschool) $125.00 (non-refundable)	Annual Registration Fee (Extended Care and Summer Camp) $65.00 (non-refundable)
Infants $180.00 per week	Preschoolers $160.00 per week
Toddler One $170.00 per week	Pre-Kindergarten State-Funded
Toddler Two $165.00 per week	Extended Care (Pre-K only) $75.00 per week
Discount for Two or More Children 15% of the total fee	Summer Camp $150.00 per week

Notes regarding payment/fees:

- At registration, the first week's tuition payment and registration fees are due.
- A $5.00 late fee is assessed for each day that the current payment is late.
- Fees are not adjusted for late arrival or early pickup.
- 2 weeks of vacation leave are granted with 1-week prior notice (this holds the child's seat). ▪ Fees are due regardless of inclement weather or school closure days.
- Late fees are due at time of pickup, otherwise it will be added to the tuition balance and must be cleared within three (3) school days.
- If payment plus late fees is not received by the close of business on Tuesday of the service week, entry will not be granted until fees are paid. Parents will be given up to two weeks to make restitution. If, after that period has expired, the account has not been settled, child/ren will be disenrolled.
- Full or partial payment will be accepted from the Department of Early Learning CAPS program and Quality Care for Children Boost program. Application forms and a CAPS or Boost contract must be submitted at the time of enrollment. If the enrollment in either program ends, the parent must set up an immediate payment plan.

Timing and Method of Payment

All payments are to be made by credit card, money order or cash on Friday prior to the week of service and must be paid no later than 10:00 a.m. on Monday of the service week.

Submit payments via:

ProCare app (download app for free Android/iPhone)

https://trinity-elc.org

Kiosk in the entry

Tuition Agreement

I agree to pay $_____ for my child(ren)'s weekly tuition for _____(Full-Time/Extended Care.

By signing this contract, the undersigned represents that the undersigned has understood and agreed to the terms and conditions of this contract. Breach of this contract in any way by the parents/guardians may result in immediate termination of childcare services.

Trinity AME ELC Executive Director

_____

Parent/Guardian Parent/Guardian