BOYS & GIRLS CLUBS OF GLOUCESTER COUNTY

For Center Use Only
Enrollment Date: _____ Start Date: _____ Staff initials _____ Member No. _____

2022-2023 Child Care Membership Application

Date _____

Member Type ☐ New Member ☐ Renewing Member

Location ☐ Glassboro Center ☐ Paulsboro Center

PRIMARY CONTACT

Role in Household ☐ Mother ☐ Father ☐ Stepparent ☐ Aunt/Uncle ☐ Sister ☐ Brother ☐ Cousin ☐ Grandparent ☐ Foster Parent ☐ Guardian ☐ Other Relative

First Name _____
Last Name _____
Suffix _____
Informal Name _____
Employer / Organization _____
Email Address _____
Phone _____
Mobile Phone _____
Address _____
City, State, Postal Code _____

Military Status

Current / Former Military ☐ Yes ☐ No

Status ☐ Active Duty ☐ Reserve/Guard ☐ Veteran

Branch ☐ Air Force ☐ Army ☐ Coast Guard ☐ Marine Corps ☐ National Guard ☐ Navy

Dept. of Defense ID Number _____

Currently Deployed (or deployed within the next 6 months) ☐ Yes ☐ No

MEMBER DETAILS

Member Information

Total past years of membership with Boys & Girls Clubs _____

First Name _____
Middle Name _____
Last Name _____
Suffix _____
Informal Name _____
Country _____
Address _____
City _____
State _____
Postal Code _____
Birthdate _____

BOYS & GIRLS CLUBS OF GLOUCESTER COUNTY

Gender	☐ Male ☐ Female ☐ Trans Male ☐ Trans Female	☐ Gender Queer ☐ Gender Non-Conforming	☐ Other ☐ Choose Not to Answer

Racial / Ethnic Identity	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American	☐ Hispanic or Latino ☐ Middle Eastern or North African ☐ Native Hawaiian or Other Pacific Islander	☐ White ☐ Bi-racial ☐ Multi-Racial ☐ Other ☐ Choose Not to Answer

Foster Care ☐ Yes ☐ No

School Lunch ☐ Free/Reduced ☐ Entire School is Free ☐ Not Eligible

School Information

Grade (Fall 2022) _____

School Name _____

Teacher _____

School Cohort/Group _____

Type of Child Care Requested

Full Day Child Care	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday
Partial Day Child Care	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday

Allergies

Food Allergies	☐ Peanuts ☐ Tree Nuts ☐ Dairy/Lactose	☐ Soy ☐ Gluten ☐ Seafood/Shellfish	☐ Eggs ☐ Other _____

Environmental Allergies	☐ Bee Stings ☐ Pollen	☐ Dust ☐ Mold	☐ Grass ☐ Other _____

Medicine Allergies	☐ Penicillin ☐ Aspirin	☐ Amoxicillin ☐ Other _____

Other Allergies	☐ Latex ☐ Perfumes/Colognes	☐ Lotions ☐ Other _____

Medical Information

Diagnosed Medical Conditions	☐ Asthma ☐ Diabetes ☐ Hearing Impairment ☐ Visual impairment	☐ ADD/ADHD ☐ Autism ☐ Seizures ☐ Anxiety/Depression ☐ Oppositional Defiance Disorder	☐ Other _____

Please list any other physical, mental or medical limitations/restrictions.

Does the member use an inhaler? ☐ Yes ☐ No

Does the member use insulin? ☐ Yes ☐ No

Does the member use an EpiPen? ☐ Yes ☐ No

Does the member self-administer medication? ☐ Yes ☐ No

Does the member receive additional support in the school/community?

☐ Individualized Education Plan (IEP)
☐ 504 (accommodation)
☐ Speech Coach
☐ Meets with school or private counselor
☐ Other _____

Insurance

Insurance Carrier _____

Group Number _____ **Member/Policy Number** _____

AUTHORIZED CONTACTS

Authorized Contact 1

Full Name _____
Phone _____
Mobile Phone _____
Work Phone _____
Emergency Contact ☐ Yes ☐ No

Relationship
☐ Caseworker ☐ Other
☐ Stepfather ☐ Other Relative
☐ Stepmother ☐ Parent
☐ Grandparent ☐ Friend
☐ Neighbor

Authorized Contact 2

Full Name _____
Phone _____
Mobile Phone _____
Work Phone _____
Emergency Contact ☐ Yes ☐ No

Relationship
☐ Caseworker ☐ Other
☐ Stepfather ☐ Other Relative
☐ Stepmother ☐ Parent
☐ Grandparent ☐ Friend
☐ Neighbor

NON-AUTHORIZED CONTACTS

Please list any individuals that are restricted from picking up the member.

Non-Authorized Contact 1

Full Name _____
Phone _____

Relationship
☐ Parent / Stepparent
☐ Grandparent
☐ Other Relative
☐ Neighbor
☐ Friend
☐ Caseworker
☐ Other

Start Date _____
End Date _____

Non-Authorized Contact 2

Full Name _____
Phone _____

Relationship
☐ Parent / Stepparent
☐ Grandparent
☐ Other Relative
☐ Neighbor
☐ Friend
☐ Caseworker
☐ Other

Start Date _____
End Date _____

BOYS & GIRLS CLUBS OF GLOUCESTER COUNTY

Household Support

Number of adults in household _____ **Number of children in household** _____

Household Composition			
☐ **Single Adult Household** ☐ **Two + Adult Household** ☐ **Self (emancipated / 18)**	**Who are the adults living in the household?** *(Check all that apply)*	☐ Mother ☐ Father ☐ Parents ☐ Stepfather ☐ Stepmother ☐ Grandparent(s)	☐ Foster Parent(s) ☐ Legal Guardian(s) ☐ Sibling(s) ☐ Uncle ☐ Aunt ☐ Other Relative(s) ☐ Other Adult(s)

Assistance Programs			
	☐ Childcare Assistance (NJCK, WFNJ, DCPP, DCF) ☐ Food Stamps/SNAP ☐ Medicaid ☐ Medicare ☐ Social Security	☐ SSI (Supplemental Security Income) ☐ SSDI (Social Security Disability Insurance) ☐ WIC (Women, Infants, and Children) ☐ TANF (Temporary Assistance for Needy Families)	☐ Veteran's Compensation ☐ Housing Assistance ☐ Other (please explain below) ☐ Choose Not to Answer ☐ None
Please describe other income sources:			

Housing Type		
	☐ Permanent (Own or Rent) ☐ Public Housing ☐ Group Home	☐ Foster Family ☐ Transitional Housing ☐ Homeless

Household Income Range				
	☐ $0 - 10,000	☐ $55,001 – 60,000	☐ $105,001 – 110,000	☐ $155,001 – 160,000
	☐ $10,001 – 15,000	☐ $60,001 – 65,000	☐ $110,001 – 115,000	☐ $160,001 – 165,000
	☐ $15,001 – 20,000	☐ $65,001 – 70,000	☐ $115,001 – 120,000	☐ $165,001 – 170,000
	☐ $20,001 – 25,000	☐ $70,001 – 75,000	☐ $120,001 – 125, 000	☐ $170,001 – 175,000
	☐ $25,001 – 30,000	☐ $75,000 – 80,000	☐ $125,001 – 130,000	☐ $175,001 – 180,000
	☐ $30,001 – 35,000	☐ $80,001 – 85,000	☐ $130,001 – 135,000	☐ $180,001 - 185,000
	☐ $35,001 – 40,000	☐ $85,001 – 90,000	☐ $135,001 – 140,000	☐ $185,001 - 190,000
	☐ $40,001 – 45,000	☐ $90,000 – 95,000	☐ $140,001 – 145,000	☐ $190,001 - 195,000
	☐ $45,001 – 50,000	☐ $95,001 – 100,000	☐ $145,001 – 150,000	☐ $195,001 - 200,000
	☐ $50,001 – 55,000	☐ $100,001 – 105,000	☐ $150,001 – 155,000	☐ $200,000+

2021-2022 CHILD AND ADULT CARE FOOD PROGRAM
LETTER TO PARENT/PARTICIPANT

Dear Parent/Participant:

Our agency depends on Child and Adult Care Food Program funds to provide meals at no separate charge to all participants. Complete information is necessary in order to receive the maximum funds available through the United States Department of Agriculture. The information will serve as documentation that our enrolled participants are eligible for the Child and Adult Care Food Program. You may complete and submit one CACFP eligibility application for all participants from the same household that are enrolled for care with our agency.

Household members include everyone in your household (such as grandparents, other relatives, or friends who live with you) who share income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you. Once properly categorized for free or reduced price benefits, whether through income or by providing a current SNAP, FDPIR, or TANF case number (SNAP, FDPIR, SSI, or Medicaid case number for Adult Day Care Participants), you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within those eligibility standards.

The income that you report must be the total gross income received by all members of your household.

The "Eligibility Income Scale" for reduced-price meals is included in this letter for your information. If your income is less than or equal to these reduced-priced standards, the participant is eligible for free or reduced-price meals from the Child and Adult Care Food Program, which means increased reimbursement for our center and increased nutritional benefits for the participant.

Please complete, sign and return the form so that our center may receive maximum reimbursement. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. This form will be placed in our files and treated as confidential information. Your cooperation is vital and appreciated.

The Child and Adult Care Food Program is available to all eligible participants regardless of race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office. To request a copy of the complaint form, call (866) 632-9992. If you have questions about any of USDA's nutrition assistance programs, check the information on the FNS web site, http://www.fns.usda.gov/cnd/. USDA is an equal opportunity provider and employer.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

Boys & Girls Clubs of Gloucester County - Glassboro Center
_____
(Name of Day Care Center)

X Theresa Root
_____
(Signature of Day Care Center Representative)

TO APPLY, YOU MUST COMPLETE ONE OF THREE OPTIONS.

1. List the Name of the participant *(First and Last Names)*.
2. Complete the Days, Hours of Care, and the meal types served to the enrolled participant. *(One time requirement for Adult Day Care participants.)*

Option 1A or 1B - CHILD CARE PARTICIPANTS ONLY:

If you receive SNAP, TANF, or FDPIR benefits for the participant, list the SNAP, TANF or FDPIR Case Number and Sign and Date the form.

If you are applying for a **Foster Child** who is under the legal responsibility of the welfare agency or court, Check the Box and Sign and Date the form.

A FOSTER CHILD'S PERSONAL USE INCOME is defined as follows:

a) Funds received from a welfare agency, which can be identified for personal use of the child. Where funds provided by the welfare agency are specified by agency, i.e., funds for shelter and care; special needs funds; and funds for personal needs such as clothing, school fees, allowances, etc., only those funds that can be identified as personal use funds shall be considered as income.

b) Money received in hand from any source. This includes, but is not limited to, funds received from trust accounts, monies provided by the child's family for personal use and earnings from employment other than occasional or part-time (e.g., paper routes, baby-sitting).

Option 2 – ADULT CARE PARTICIPANTS ONLY:

If you receive SNAP, FDPIR, SSI or Medicaid benefits for the participant, indicate the SNAP, FDPIR, SSI or Medicaid Case Number and Sign and Date the form.

Option 3 – CHILD CARE AND ADULT PARTICIPANTS:

If you do not receive SNAP, TANF, FDPIR, SSI or Medicaid benefits for the participant, you must complete:

3. Names of all *(Related or Unrelated)* household members
4. List the household income *(Monthly Gross Earnings)* for each household member.
5. Total number in household *(#1 + #3 above)*.
6. Total the gross income of all household members.
7. Sign, Print and complete the full address of the Adult Household Member signing the application.
8. Date the form and complete the telephone number of Adult Household Member signing the application.
9. List the last four (4) digits of the social security number for the Adult Household Member signing the application or indicate that the Adult Household Member signing the application does not possess a social security number.

ELIGIBILITY INCOME SCALE
Effective from July 1, 2021 to June 30, 2022

HOUSEHOLD SIZE	REDUCED		
	ANNUAL	MONTHLY	WEEKLY
1	$16,745 - $23,828	$1,397 - $1,986	$ 323 - $ 459
2	$22,647 - $32,227	$1,889 - $2,686	$ 437 - $ 620
3	$28,549 - $40,626	$2,380 - $3,386	$ 550 - $ 782
4	$34,451 - $49,025	$2,872 - $4,086	$ 664 - $ 943
5	$40,353 - $57,424	$3,364 - $4,786	$ 777 - $1,105
6	$46,255 - $65,823	$3,856 - $5,486	$ 891 - $1,266
7	$52,157 - $74,222	$4,348 - $6,186	$1,004 - $1,428
8	$58,059 - $82,621	$4,840 - $6,886	$1,118 - $1,589
Each Additional Family Member	**+8,399**	**+700**	**+162**

2022 NEW JERSEY CHILD AND ADULT CARE FOOD PROGRAM
ELIGIBILITY APPLICATION

NAME(S) & AGE(S) OF ENROLLED PARTICIPANT _____ _____; _____ _____
(Name) (Age) (Name) (Age)

OPTIONAL: *RACIAL/ETHNIC IDENTITY OF PARTICIPANT*

Check one ETHNIC identity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Mark one or more RACIAL identity (ies):

◯ American Indian or Alaska Native ◯ Asian ◯ Black or African American
◯ Native Hawaiian or Other Pacific Islander ◯ White

Enrollment Information

Check (√) each day *the above participant is enrolled for care, the* ***hours of care*** *each day, and the* ***meal type(s)*** *served:*

DAYS OF CARE: ☐ *MON* ☐ *TUES* ☐ *WED* ☐ *THURS* ☐ *FRI* ☐ *SAT* ☐ *SUN*

HOURS OF CARE: ___ - ___ ___ - ___ ___ - ___ ___ - ___ ___ - ___ ___ - ___ ___ - ___
Swing / Rotating Shifts: (If Applicable) ___ - ___ ___ - ___ ___ - ___ ___ - ___ ___ - ___ ___ - ___ ___ - ___

MEAL TYPES SERVED: ☐ ***BREAKFAST*** ☐ ***A.M. SUPPLEMENT*** ☐ ***LUNCH*** ☐ ***P.M. SUPPLEMENT*** ☐ ***DINNER***

CHILD DAY CARE FOOD PROGRAM PARTICIPANTS ONLY

OPTION 1A: **BENEFICIARIES of Supplemental Nutrition Assistance Program (SNAP)** *(formerly Food Stamps)***, Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR)**

If you are now receiving SNAP,TANF or FDPIR for this child, complete **one** of the following numbers:

SNAP CASE #_____ *OR* TANF CASE #_____ *OR* FDPIR CASE # _____

OPTION 1B: **FOSTER CHILD**

If you are applying for a foster child, check the box and list any personal income which has been identified by specific category such as clothing, school fees, allowances, etc.:

FOSTER CHILD ☐ **INCOME $**_____

ADULT DAY CARE FOOD PROGRAM PARTICIPANTS ONLY

OPTION 2: **BENEFICIARIES of SNAP, FDPIR, SSI or Medicaid**

If you are now receiving SNAP, SSI, FDPIR or Medicaid complete **one** of the following numbers:

SNAP #_____ *OR* FDPIR CASE # _____ *OR* SSI CASE # _____ *OR* MEDICAID CASE #_____

OPTION 3: HOUSEHOLD ELIGIBILITY - COMPLETE IF YOU DID NOT COMPLETE OPTION 1A, OPTION 1B, OR OPTION 2

Complete the following information: Household Members, Social Security Numbers and Income.

NAMES OF ALL OTHER HOUSEHOLD MEMBERS: (*Related and Unrelated*)	MONTHLY INCOME *(Complete One Or More - Before Deductions)*				
	MONTHLY (Gross Earnings) WAGES / SALARY	MONTHLY SOCIAL SECURITY PENSIONS RETIREMENT	MONTHLY UNEMPLOYMENT **WORKMEN'S** COMPENSATION	MONTHLY WELFARE CHILD SUPPORT ALIMONY	MONTHLY ANY OTHER INCOME
1.	$	$	$	$	$
2.	$	$	$	$	$
3.	$	$	$	$	$
4.	$	$	$	$	$
5.	$	$	$	$	$
6.	$	$	$	$	$
7.	$	$	$	$	$
8.	$	$	$	$	$
9.	$	$	$	$	$
10.	$	$	$	$	$
TOTAL NUMBER IN HOUSEHOLD ***(INCLUDE ENROLLED PARTICIPANT):*** _____					
TOTAL GROSS HOUSEHOLD INCOME:				$ _____	

ADULT HOUSEHOLD MEMBER SIGNATURE and LAST FOUR DIGITS of SOCIAL SECURITY NUMBER: ***(See Privacy Act Statement below)***

An Adult Household Member must sign and date this form, and list the last four (4) digits of his or her Social Security Number.
If you do not have a social security number, mark the box (☒) - "I do not have a Social Security Number".

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that the Food Stamp, TANF, SSI, or Medicaid Number of the enrolled participant is correct, or that all income is reported. I understand that this information is being given for the receipt of Federal funds issued to the day care center based on the information I provide. I understand that CACFP officials may verify this information; and that deliberate misrepresentation may result in the participant losing meal benefits, and I may be prosecuted under the applicable State and Federal laws. ***An Adult Household Member must complete the following:***

Signature: _____ Address:_____

Print name: _____ City: _____ State: _____ Zip Code: _____

Date: _____ Phone Number:_____

Last four (4) digits of Social Security Number: * * * - * * * - ____ ☐ **I do not have a Social Security Number**

PRIVACY ACT STATEMENT: The National School Lunch Act requires that, unless the participants' Case Number is provided, you must include the Social Security Number of the adult household member signing the application or indicate that the household member does not have a Social Security Number. Provision of a Social Security Number is not mandatory, but if a Social Security Number is not given or an indication is not made that the signer does not have such a number, the participant cannot be determined eligible for free or reduced priced menus. The Social Security Numbers may be used to identify you for verifying the correctness of information stated on the application. These verifications may include audits, investigations and may include contacting employers to determine income, contacting a Food Stamp or TANF office to determine current certification for receipt of Food Stamps or TANF benefits, contacting the State Employment Security office to determine the amount of benefits received and checking the documentation produced by household members to verify the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims or legal actions if incorrect information is reported. These acts must be told to all household members whose Social Security Numbers are reported on this form.

TO BE COMPLETED BY DAY CARE AGENCY ONLY - DO NOT WRITE BELOW THIS LINE

Determination: Free _____ Reduced _____ Paid _____

Signature of Determining Official:

_____ Date_____

TOTAL MONTHLY INCOME $_____

Conversion factors to figure monthly income: Weekly x 4.33
Twice a month x 2
Every 2 weeks x 2.15

County of Gloucester
2022 CDBG Self-Certification Form

This program receives assistance from County of Gloucester's Community Development Block Grant Program. The Program, funded by the U.S. Department of Housing and Urban Development (HUD), requires us to collect specific information about our program participants. This information will be kept confidential and will only be provided to HUD in summarized reports.

CDBG Program Name: Boys & Girls Clubs of Gloucester County's Youth Services

Program Participant's Name: _____

Street Address: _____

City, State, Zip Code: _____

Household Size: _____ (number of people in household)

In the first column of the chart below, find your family size then check the box next to the income level that best describes your family's current annual income. Total family income includes income from all sources (wages, unemployment, social security, public assistance, interest and dividends, worker's comp, etc.) for all members of your family who are at least 18 years of age. A family is defined as all persons living in the same household who are related by birth, marriage, or adoption.

Household Size	Extremely Low Income	Low Income Limits	Moderate Income	Other
1 Person	$22,150 or less	$22,151 to $36,900	$36,901 to $59,050	Above $59,051
2 Person	$25,200 or less	$25,201 to $42,200	$42,201 to $67,450	Above $67,451
3 Person	$28,450 or less	$28,451 to $47,450	$47,451 to $75,900	Above $75,901
4 Person	$31,600 or less	$31,601 to $52,700	$52,701 to $84,300	Above $84,301
5 Person	$34,150 or less	$34,151 to $56,950	$56,951 to $91,050	Above $91,051
6 Person	$37,190 or less	$37,191 to $61,150	$61,151 to $97,800	Above $97,801
7 Person	$41,910 or less	$41,911 to $65,350	$65,351 to $104,550	Above $104,551
8 Person	$46,630 or less	$46,631 to $69,600	$69,601 to $111,300	Above $111,301

Race of Program Participant (must check one):

☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native
☐ Asian White ☐ Black/African American & White ☐ Asian/Pacific Islander
☐ American Indian/Alaskan Native & Black/African American ☐ Other multi-racial
☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaskan Native & White

Ethnicity of Program Participant (must check one):

☐ Hispanic ☐ Non-Hispanic

Financial Hardship from COVID-19 & Certification:

I attest my household has lost employment or income either permanently or temporarily due to the COVID-19 pandemic. I attest that the information provided is true and correct to my knowledge. I understand that the information listed on this form may be subject to verification by the County of Gloucester and/or by the U.S. Department of Housing and Urban Development (HUD), the Office of the Inspector General, or their authorized representatives.

_____ _____

Head of Household Signature Date

WARNING: Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government.

WAIVERS & RELEASES

Data Collection

☐ Yes	☐ No	I give my permission to the Boys & Girls Clubs of Gloucester County (BGCGC) to collect information via online or written surveys, questionnaires, interviews and focus groups from the minor child listed on this application. Any and all information received will be kept strictly confidential. Data gathered through these means will be summarized in the aggregate and will exclude all references to any individual responses. The aggregated results of these analyses may be shared with Club staff, BGCA, funders, and other community stakeholders to evidence program effectiveness and/or Club impact on our members. This release may be revolved at any time by contacting the BGCGC in writing.

Medical

☐ Yes	☐ No	I give permission to the Boys & Girls Clubs of Gloucester County to seek emergency medical treatment for my minor child if I cannot be reached. I will be responsible for any/all costs of medical attention and treatment.

Technology

☐ Yes	☐ No	As a member of the Boys & Girls Clubs of Gloucester County, our child may have access to the internet. While the Boys & Girls Club of Gloucester County has rules prohibiting such conduct and precautions are taken by the Club to prevent such access, it is possible your child may access inappropriate sites. The Boys & Girls Club of Gloucester County will not be responsible for such unauthorized access.

Transportation

☐ Yes	☐ No	Parents/Guardians and Club members may be responsible for their own transportation to and from the Club, unless otherwise specified.

Data Sharing

☐ Yes	☐ No	I give my permission to the BGCGC to share information about the minor child listed on this application with BGCA for research purposes and/or to evaluate the program's effectiveness. Information that will be disclosed to BGCA may include the information provided on this membership application form, information provided by the minor child's school or school district, and other information collected by BGCGC, including data collected via surveys or questionnaires. All information provided to BGCA will be kept confidential. This release may be revoked at any time by contacting the BGCGC in writing.

Press / Media

☐ Yes	☐ No	I give my permission for my child's picture, video image, or any other graphic depiction or likeness, to be used by Boys & Girls Clubs of Gloucester County, Boys & Girls Clubs of America and its affiliates or donors and acknowledge neither my child nor I will receive payment for same.

Miscellaneous

☐ Yes	☐ No	I understand that the Boys & Girls Clubs of Gloucester County is not responsible for lost or stolen items. Each Club has the right to make membership decisions based on the resources and capacity of their facility and staff. BGCGC reserves the right to decline the application, rescind the enrollment of, or suspend any youth that cannot successfully associate with other club members.

Annual Membership Fee:

The Club Membership fee is $15 per year and non-refundable. Membership must be renewed each year to continue participation in the Club's programs.

(Please Initial)

Parent Handbook

_____I have received the Information to Parents Document, Policy on the Release of Children, Management of Communicable Disease, Discipline and Suspension/Expulsion Policies, Reporting Suspected Child Abuse and Neglect.

Late Pick-up

_____ The School-Aged Child Care Program ends at 6:00 pm. If you are late in picking your child up, the first time is a warning. The second time there is a cost of $5.00 for every 10 minutes or part of, per child.

Fees and Costs:

_____The School-Aged Child Care private pay rate is based on family income. Discount applied when payment is made in advance of service. Separate application can be submitted for subsidized fee rates. A fee agreement will be created that details fees and weekly costs for the child.

APPLICATION APPROVAL
I, the parent/guardian of the minor child listed on this application, on behalf of the minor child listed herein and for ourselves, our heirs, executors and administrators, hereby release, waive, acquit and forever discharge the Boys & Girls Clubs of Gloucester County, Inc. (BGCGC) and Boys & Girls Clubs of America (BGCA), their representatives, successors, insurers, assigns or any other person or entity associated with any of the above organizations such as staff, directors or volunteers, from all liability, claims, demands, or causes of action for any and all loss, damage, injury or death and any claim of damages resulting from use of facilities owned or controlled by the above organizations, or participation in activities of said organizations either at or away from the Club. My signature below attests that all of the above information is correct. As a parent/guardian of the above participating child, I certify that he/she is in good physical health and may participate in all of the activities of the Boys & Girls Clubs of Gloucester County, except as noted above. I certify that I have read all of the above information and understand it fully. *Your signature below confirms that all information above is true and accurate.*
Parent/Guardian Signature **Date**

BOYS & GIRLS CLUBS
OF GLOUCESTER COUNTY

Application for a Reduced Rate

☐ Glassboro ☐ Paulsboro

Please complete this form in its entirety and attach all registration and income verification documentation. Incomplete forms will delay the process and may cause you to lose your scholarship.

Child's Name:_____ Age:_____

Sibling(s) Name(s):_____ Ages:_____

Sibling(s) Name(s):_____ Ages:_____

Parent/Guardian Contact _____ Contact #:_____

Program requesting reduction for: Summer Camp After School Care

Cost of the program per child per week:_____

Dates you are requesting rate reduction:_____

Please tell us in the space provided why this program is important and why you need financial assistance.

_____

_____

_____

_____

Number of adults in your household:_____ Number of Children in your household:_____

******You must provide documentation to verify this number (last year's tax return or months worth of most recent pay stubs.)***

Household income (includes salary, child support, welfare, unemployment, food stamps etc.)

Total household income annually _____

Other sources of financial aid
Gloucester County CCR&R - (856) 537-2322
6 North Broad Street, Suite 300, Woodbury, NJ 08096

BOYS & GIRLS CLUBS
OF GLOUCESTER COUNTY

Minor Participant Waiver, Release, Indemnification of All Claims & Covenant Not to Sue

NOTICE: THIS IS A LEGALLY BINDING AGREEMENT. Read this document carefully and in entirety. By signing this agreement, you give up your right and the named minor's right to bring a court action to recover compensation or obtain any other remedy for any personal injury or property damage however caused arising out of the named minor's participation in Boys & Girls Clubs of Gloucester County (hereinafter referred to as BGCGC) Programs, now or any time in the future.

Acknowledgment of Risk

I, in my legal capacity as the parent/guardian of the minor named below, do hereby acknowledge and agree that participation in BGCGC activities comes with inherent risks. I have full knowledge and understanding of the inherent risks associated with BGCGC program participation, including but in no way limited to: (1) slips, trips, and falls, (2) aquatic injuries, (3) athletic injuries, and (4) illness, including exposure to and infection with viruses or bacteria. I further acknowledge that the preceding list is not inclusive of all possible risks associated with BGCGC program participation and that said list in no way limits the operation of this Agreement.

Coronavirus / COVID-19 Warning & Disclaimer

Coronavirus, COVID-19 is an **extremely contagious** virus that spreads easily through person-to-person contact. Federal and state authorities recommend social distancing as a mean to prevent the spread of the virus. **COVID-19 can lead to severe illness, personal injury, permanent disability, and death. Participating in BGCGC programs or accessing our Center facilities could increase the risk of contracting COVID-19.** BGCGC in no way warrants that COVID-19 infection will not occur through participation in BGCGC programs or accessing any of BGCGC facilities.

Waiver, Release, Indemnification & Covenant Not to Sue

In consideration of _____'s participation in BGCGC programs, I, the parent/guardian of the minor named above, agree to release and on behalf of myself and the minor named above, my heirs, representatives, executors, administrators, and assigns, HEREBY DO RELEASE BGCGC, its officers, directors, employees, volunteers, agents, representatives and insurers ("Releasees") from any causes of action, claims, or demands of any nature whatsoever including, but in no way limited to, claims of negligence, which I, the named minor, my heirs, representatives, executors, administrators and assigns may have, now or in the future, against BGCGC on account of personal injury, property damage, death or accident of any kind, arising out of or in any way related to the use of BGCGC facilities/equipment or participation in BGCGC

programs whether that participation is supervised or unsupervised, however the injury or damage occurs, including, but not limited to the negligence of Releasees.

In consideration of the named minor's participation in BGCGC, I, the undersigned parent/guardian of the named minor, agree to INDEMNIFY AND HOLD HARMLESS Releasees from any and all causes of action, claims, demands, losses, or costs of any nature whatsoever arising out of or in any way related to the named minor's BGCGC program participation.

I hereby certify on behalf of myself and the named minor that I have full knowledge of the nature and extent of the risks inherent in BGCGC program participation and that I, on behalf of myself and the named minor, am voluntarily assuming said risks. I understand that I and the named minor will be solely responsible for any loss or damage, including personal injury, property damage, or death, the named minor sustains while participating in BGCGC programs and that by signing this agreement I, on behalf of myself and the named minor, HEREBY RELEASE Releasees of all liability for such loss, damage, or death. I further certify that the named minor is in good health and has no conditions or impairments which would preclude his/her safe participation in BGCGC programs.

I further certify that my date of birth is _____ (MM/DD/YYYY), that my present age is _____, that I am therefore of lawful age (18 years or older) and otherwise legally competent to sign this agreement, and that I have legal capacity to act as the parent/guardian of the named minor. I further understand that the terms of this agreement are legally binding and certify that I am signing this agreement, after having carefully read it, of my own free will.

_____ _____

Participant Name (Print Clearly) Date

_____ _____

Parent/Guardian Signature Parent/Guardian Name (Print Clearly)

BOYS & GIRLS CLUBS
OF GLOUCESTER COUNTY

School Age Care & Summer Camp Collections Policy

Upon school age care and/or summer camp enrollment, a signed fee agreement and any membership, registration and first week assessed fees must be collected before the child(ren) can begin attending. If the parent plans on paying every two weeks, then they should pay for two weeks prior to starting to continue with following the policies of the organization. Autobilling will be done on Wednesdays prior to care (Ex: Wed. June 3rd autobill for week 6/8 care). An account balance report will be run by the Club Access Coordinator after the autobilling process is complete.

Parent/Guardians will have until the close of business on Monday to be pay for that week of care. Any balances unpaid on Tuesday will be issued a past due invoice and parent/guardian will be contacted. Unless payment arrangements or circumstances are validated and approved by the Center Director, the child(ren) will not be permitted to return until the account is reconciled.

I hereby acknowledge receipt of the School Age and Summer Camp Collections Policy**.** I understand and agree that it is my responsibility to read and comply with this policy.

_____

Enrolled Child(ren) in household

_____ _____

Parent/Guardian Signature Date

BOYS & GIRLS CLUBS
OF GLOUCESTER COUNTY

Recurring Payment Authorization Form

If you would like to enjoy the convenience of automatic recurring billing, simply complete the Credit Card Information section below and sign the form. All requested information is required. Upon approval, we will automatically bill your credit card for the amount indicated and your total charges will appear on your monthly credit card statement. You may cancel this automatic billing authorization at any time by contacting us.

merchant

Customer Information (to be completed by merchant)

Customer/company Boys & Girls Clubs of Gloucester County, Inc.

Contact name Theresa Root Account number School Year 2022-2023

Email address troot@gcbgc.org Phone (856) 881-6084 Ext: 1100

Payment Information (to be completed by merchant)

I authorize Boys & Girls Clubs of Gloucester County, Inc. to automatically bill the card listed below as specified:

Child(ren) Name: _____

Recurring amount _____

Frequency (check one) ☐ Once ☐ Daily ☐ Weekly ☐ Twice/month ☐ Monthly ☐ Quarterly

Start on ____/____/____ (Month/Day/Year) End on: (check one) ☐ ____/____/____ (Month/Day/Year)

☐ No end date

Email Address for payment receipts: _____

customer

Credit Card Information (to be completed by customer)

Card type ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____

Cardholder name (as shown on card) _____ Cardholder ZIP Code (from credit card billing address) _____

Card number _____ CSV: _____ Expires ____/____

☐ Notify me via email when my credit card is charged. (Make sure email address above is correct.)

_____ _____

Customer's signature Date