FRIENDSHIP HOUSE
OF CHRISTIAN SERVICE

YOUTH PROGRAM SUMMER 2024

Please complete **ALL** forms included in this packet.

Bring this packet & the following items to Friendship House to complete registration:

1. **For new applicants**: Complete Online Registration www.friendshipmt.org
2. Enrolled with Express Pay Online for donations
3. **Enrolled** in Best Beginnings **OR**
4. Have a Best Beginnings **denial letter** and:
   a. TWO (2) most recent pay stubs for **ALL household members**
   b. Most recent federal tax return filed for **ALL household members** (please redact Social Security Number prior to submitting)
5. The following items brought to Friendship House:
   a. This packet, **fully completed**
   b. A copy of your child's **current immunizations** (you can have them faxed to 406-545-4901)
   c. Copy of your child's **insurance/Medicaid card**

Programming goes from **June 3rd through August 23.**

Friendship House will be **closed July 4-5.**

Packets will NOT be accepted by the Front Office until the entire packet is completed and accompanied documents are turned in. Enrollment is on a first come, first served basis.

Friendship House of Christian Service
3123 8th Ave South Billings, MT 59101 (406) 259-5569

Referred by _____

FRIENDSHIP HOUSE
OF CHRISTIAN SERVICE

YOUTH PROGRAM
SUMMER 2024
ENROLLMENT INFO
REGISTRATION FORM

Child's First Name:_____ Child's Last Name: _____
Student State ID:_____(You can get this 9-digit number from your child's school)

Gender: ☐ MALE ☐ FEMALE Date of Birth:___/___/___ Shirt Size: Youth or Adult_____

Race/Ethnicity (choose all that apply):

☐ Caucasian ☐ Hispanic or Latino ☐ African American

☐ American Indian ☐ Native Hawaiian or Other Pacific Islander

☐ Asian ☐ Mixed Ethnicity

What grade WILL your child be enrolled in for the 2024-2025 School Year?

☐ Kindergarten ☐ 1st Grade ☐ 2nd Grade ☐ 3rd Grade

☐ 4th Grade ☐ 5th Grade ☐ 6th Grade ☐ 7th Grade

What school WILL your child attend in Fall 2024?

☐**SCHOOL 2024-2025**_____

DPHHS CCL 113 Revision
Date: June 2023

Emergency Contact and Consent

This form must accompany staff when children are away from the childcare site

Child's Name (First, Last)	
Date of Birth	

ALLERGY ALERT **Does your child have allergies? ☐ YES ☐ NO If yes, list all allergies in required box.**

Parent or Guardian Contact Information

Name (First, Last)		Relationship
Home Address (Street, City, Zip)		
Primary Phone	Email Address	
Address (Street, City, Zip)		Work Phone
Name (First, Last)		Relationship
Home Address (Street, City, Zip)		
Primary Phone	Email Address	
Address (Street, City, Zip)		Work Phone

Required Emergency Contact Information – person other than parent or guardian that is authorized to pick up child

Name (First, Last)	Phone	Relationship
Name (First, Last)	Phone	Relationship
Name (First, Last)	Phone	Relationship

Required Medical Information

Primary Medical Care Provider	Phone
Health Concerns (Please explain)	
Allergies	

Parent or Guardian Authorization

In an emergency, the child care facility has my permission to provide or obtain emergency medical treatment including transporting child by ambulance or vehicle if necessary. The parent/guardian of the child will be notified as soon as possible.

Parent/Guardian Signature **Date**

(This form must be completed and signed annually)

21st Century Community Learning Center (21st CCLC)

Friendship House of Christian Service
3123 8th Ave South Billings MT 59101
406-259-5569
*Safe*Fun*Engaging*Educational*

DISCIPLINE & DISCHARGE POLICY

Children are entitled to a pleasant and harmonious environment at the 21st Century Programs. The 21st Century cannot serve children who display chronically disruptive behavior. Chronically disruptive behavior is defined as verbal or physical activity which may include but is not limited to such behavior that:

- Requires constant attention from the staff
- Inflicts physical or emotional harm on other children
- Abuses the staff
- Ignores or disobeys the rules which guide behavior

The supervisor has the discretion to not allow any misbehaving student during the program day to attend the Afterschool/Summer Program in the future.

Teachers use Restorative Practices to assist children in the 21st Century Program setting. This practice teaches the students how to reflect, resolve conflicts, and how to self-regulate. Steps taken by staff include:

1. The misbehaving child will be redirected privately, if resolved, no further action taken.
2. Continuation of misbehavior: teachers will ask Restorative Inquiry Questions with all involved. If behavior is resolved, no further action taken.
3. Continuation of misbehavior: supervisor/teacher will conduct a Restorative Circle with the class to create a plan for restorative community. At this point the caregiver will be contacted. If the problem is resolved there will be no further action.
4. If the behavior is not resolved, a behavior incident report will be written, and the supervisor will contact the caregiver to schedule a meeting. The meeting will include the supervisor, caregiver, and student to develop a behavioral contract with specific consequences for continued inappropriate behavior. The child will then be asked to stay home for the next two days of the program. The behavior report will be given to the Director.
5. If a child receives three written behavior-related incident reports within a program year, the child will be suspended.
6. If the severity of a problem is great enough, discharge will be effective immediately.

I have read the discipline requirements of the 21st Century Program, and understand that I must obey the rules in order to stay in the 21st Century Program.

_____	_____	_____
Student Name	*Parent Signature*	*Date*

FRIENDSHIP HOUSE
OF CHRISTIAN SERVICE

IMMUNIZATION REQUIREMENTS

Friendship House is a Licensed Child Care Center through the State of Montana. Children that do not have proof of current immunizations will not be enrolled at Friendship House.

The State of Montana states: Before a child may attend a Montana day care facility, that facility must be provided with the documentation showing that the child has been immunized as required for the child's age group against measles, rubella, mumps, poliomyelitis, diphtheria, pertussis (whooping cough), tetanus, varicella, hepatitis B, pneumococcal, and Haemophilus influenza type B.

Vaccines	**# of Doses**
DTaP	4 doses
Hepatitis B	3 doses
Hib	3-4 doses (depending on vaccine type)
Polio	3 doses
PCV	4 doses (not required after 5 years of age)
MMR	1 dose (2nd by Kindergarten)
Varicella	2 dose (2nd by Kindergarten)

Immunizations are easily obtained by your child's doctor's office or school. You can have them faxed to Friendship House at 406-545-4901

DPHHS-QAD/CCL-120
(Revision 06-07)

NON-INGESTIBLE OVER THE COUNTER (OTC) MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT

Child's Name_____ Date of Birth_____/____/___
Program Name_____ Today's Date_____/____/___

****

***** **I give permission for the administration of following non-ingestible over the counter medications (mark all that apply):**

☐ Diaper Rash Cream/Ointments

☐ Insect Repellent

☐ Sunscreen

☐ Cortisone/Anti-Itch Creams/Ointments

☐ Medicated Lip Treatments

☐ OTC Antibiotic Creams/Ointments

☐ Burn Creams/Sprays

☐ Other Non-Ingestible OTC's: (Please Specify)_____

☐ _____
☐ _____
☐ _____

To administer a non-ingestible over the counter (OTC) medication:

- The OTC medication must be brought to the day care facility from the parent;
- The OTC medication must be in its original container, with a legible label, and expiration date of medication;
- The child's name must be on the original container

Special handling/storage Instructions_____ Refrigeration Y/N

Parent/Guardian Signature (required)_____

*** This document must be updated on an annual basis.**

Unused Medication: Returned to Parent Y/N or Discarded Appropriately (circle one)

By:_____ Date_____/_____/_____

***Keep in the child's file when medication is finished.**

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. This child care center 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 Meal Benefit Income Eligibility Form. 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 Meal Benefit Form for each of my children in child care? You may complete and submit one CACFP Meal Benefit Income Eligibility Form for all children enrolled in child care in your household **only** if the children in child care 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 your child care center.

2. Who can get free meals without providing income information? Children in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Food Distribution Program on Indian Reservations (FDPIR), or Temporary Assistance for Needy Families (TANF) can get free meals. Foster children and children enrolled in Head Start are also 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 Eligibility Guidelines.

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 child care center.

5. Who should I include as members of my household? You must include everyone 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 Income Eligibility Guidelines chart, the center will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or by providing a current SNAP, FDPIR, or TANF case number, 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 the eligibility standards.

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

8. What if I have foster children? 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 Meal Benefit Form, 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 your child care center director.

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. ***(Pricing program only)*** **Will the information I give 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 child care center.

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 your child care center.

INSTRUCTIONS FOR COMPLETING THE CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

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Follow these instructions, if your household gets SNAP, FDPIR or TANF:

Part 1: List all enrolled children and household members.
Part 2: List the case number for any household members (including adults) receiving [SNAP], [FDPIR] or [TANF] benefits.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. The last four digits of a Social Security Number are **not** necessary.
Part 6: Answer this question if you choose.
Part 7: Skip this part.

If you are applying *only* on behalf of a foster child, follow these instructions:

If **all** children you are applying for are foster children, or if you are **only** applying for benefits for the foster child:

Part 1: List all foster children. Check the box indicating that the child is a foster child.
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. A Social Security Number is **not** necessary.
Part 6: Answer this question which is required.
Part 7: Skip this part.

If some of the children in the household are foster children:

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income" box. Check the box if the child is a foster child.
Part 2: If the household does not have a case number, skip this part.
Part 3: If any child you are applying for is homeless, migrant, or a runaway, call the State agency for instructions.
Part 4: Follow these instructions to report total household income from this month or last month.

Column A – Name: List only the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly. If no income, please write a zero.

Box 1: List the **gross income,** not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your pay stub or your boss can tell you.
Box 2: List the amount each person got for the month from welfare, child support, and alimony.
Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.
Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, report income after expenses in Box 1. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of his/her Social Security Number or mark the box if s/he doesn't have one.
Part 6: Answer this question if you choose.
Part 7: Sign here if you choose not to provide household size and income information.

ALL OTHER HOUSEHOLDS, follow these instructions:

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box."

Part 2: Skip this part.

Part 3: If any child you are applying for is homeless, migrant, or a runaway, call the State agency for instructions.

Part 4: Follow these instructions to report total household income from this month or last month.

Column A – Name: List only the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the **gross income,** not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your pay stub or your boss can tell you.
Box 2: List the amount each person got for the month from welfare, child support, and alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, report income after expenses in Box 1. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of his/her Social Security Number or mark the box if s/he doesn't have one.

Part 6: Select ethnicity and race for the children listed to be attending care.

Part 7: Sign here if you choose not to provide household size and income information.

Privacy Act Statement: This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.

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CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Institution or Facility Name:

Part 1. Name of Child(ren) Enrolled:

	☐
	☐
	☐
	☐
Full names of all household members	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.

Part 2. Benefits: If any member of your household received [SNAP], [FDPIR] or [TANF cash assistance], provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:_____ CASE NUMBER: _____

Part 3. If any child you are applying for is homeless, a migrant, or a runaway, call the State agency for instructions.

Part 4. Total Household Gross Income—You must tell us how much and how often (whole dollar amounts, please)

Total number in household: _____

A. Name (List **only** household members with income)	**B. Gross income and how often it was received** *(if $0, please write $0. Any field left blank will be accepted as representative of "no income"* 1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All other income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

This section required for all forms listing income in Part 4:

Last four digits of Social Security Number: X X X - X X - _ _ _ _ ☐ I do not have a Social Security Number

Part 5. Signature (Adult must sign)

An adult household member must sign this form.

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.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Part 6. Participant's ethnic and racial identities

Mark one ethnic identity:	Mark one or more racial identities:
❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ Asian ❑ American Indian or Alaska Native ❑ Black or African American ❑ White ❑ Native Hawaiian or Other Pacific Islander

Part 7. Decline to provide information

I choose not to provide information about my household size and income.

_____ _____

Signature of Adult Household Member Date

*****This Section is to be completed by the Child Care Institution – Determination of Eligibility*****

Completion of this section is required for the institution to claim meals at the free or reduced rate for the child/children listed in Part 1: Name of Child(ren) Enrolled.

Number of persons in the household: _____

Total income $ _____ Per: ❑Week ❑Every 2 Weeks ❑Twice A Month ❑Month ❑Year

(Annual Income Conversion: weekly x 52, every 2 weeks x 26, twice a month x 24, monthly x 12)

Categorical Eligibility: ❑Free ❑Reduced ❑Paid ❑Tier I ❑Tier II

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

Additional official signatures are recommended but not required.

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date: _____

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Food Distribution Program on Indian Reservations (FDPIR), or Temporary Assistance for Needy Families (TANF) case number for the participant or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: "In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on 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. 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. 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, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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; (2) Fax: (202) 690-7442; or (3) Email: program.intake@usda.gov. This institution is an equal opportunity provider."

Head Start: Children who are enrolled in the Federal Head Start Program receive meal benefits in the CACFP without further application or eligibility determination. Acceptable documentation includes a current approved Head Start application or a written, signed and dated statement or roster from a Head Start official. [USDA Memos CACFP 7-2008 and CACFP 10-2008]

FRIENDSHIP HOUSE
COUNSELING SERVICES
INFORMED CONSENT FORM

FRIENDSHIP HOUSE COUNSELING is a confidential service to assist children, parents and families with mental health/mental wellbeing concerns come to a greater understanding, and learn effective child, parent and family coping strategies to ·assist in better daily living. Counseling involves a relationship between the child, parent, family and our licensed clinical professional counselor who has the training, desire and willingness to help accomplish identified goals, Counseling involves teaching about mental wellbeing; intervening in problem behavior which impairs healthy development; building personal strengths; working as a team to insure positive coping skills in school, with peers and family members; and assist in connecting to community resources that may be appropriate. While counseling, there may be periods of increased anxiety or confusion. The outcome of counseling is often positive; however, the level of satisfaction for any individual is not predictable. Your counselor is available to support you throughout the counseling process.

CONFIDENTIALITY:

All interactions with Counseling Services, including scheduling of or attendance at appointments, content of your sessions, progress in counseling, and· your records are confidential. No record of counseling is contained in any academic or educational file. You may request in writing that the counseling staff release specific information about your counseling to persons you designate.

EXCEPTIONS TO CONFIDENTIALITY:

- The counseling staff works as a team with Friendship House team members. Your counselor may consult with Friendship House staff to provide the best possible care.
- If there is evidence of clear and imminent danger of harm to self and/or others, a counselor is legally required to report this information to the .authorities responsible for ensuring safety.
- Montana state law requires that staff of Counseling Services who learn of, or strongly suspect, physical or sexual abuse or neglect of any person under 18 years of age must report this information to county child protection services.
- A court order, issued by a judge, may require the Counseling Services staff to release information contained in records and/or require a counselor to testify in a court hearing.

  Fees for Friendship House Counseling services are processed with your family health insurance; however, counseling services will not result in any additional cost to you beyond your program fees.

  I have read above information and understand it. I will contact Friendship House's Counseling Team if I have questions or concerns. I understand the risks and benefits of counseling, the nature and limits of confidentiality, and what is expected of me as a client of the Counseling Services or a parent/ guardian of a counselee.

_____ _____

Printed Name of Child Signature of Therapist

_____ _____

Printed name of Parent/Guardian Signature of Parent/Guardian

_____

Date

FRIENDSHIP HOUSE
COUNSELING SERVICES
PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for trusting Friendship House Counseling to provide mental health services. We are committed to providing you with the highest quality care. We ask that you read and sign this form to acknowledge your understanding of our financial responsibilities policies.

Patient Financial Responsibilities Include:

- The child (or child's guardian) is ultimately responsible for the payment for treatment and care
- We will bill your insurance for you. However, you will need to provide the most correct and updated information regarding insurance
- Friendship House will bill your insurance and accept for payment whatever the insurer provides. There will be no additional costs to you
- By my signature below, I hereby authorize assignment of financial benefits directly to Friendship House and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form

_____ _____

Parent/Guardian Signature Date

_____

Child Name

FRIENDSHIP HOUSE
OF CHRISTIAN SERVICE

Donation Agreement Form Summer 2024

Friendship House account statements are printed at the beginning of every month. We require that students attend Friendship House programs **a minimum of three days a week and at least two hours a day**. We require that you notify the Friendship House Front Office if your child will be absent by 10AM on the day of absence.

- We require that you either have the Best Beginnings Scholarship or a denial letter from Best Beginnings for our records.
- Best Beginnings Scholarship through HRDC. Please inform Case Manager if child is at **PV 76060 Friendship House** or **PV 107389 Orchard Site**.
- **Please provide your HRDC Case Manager Name: _____**

Parent's Covenant of Donation Support

Friendship House is a Faith-Based Non-Profit Neighborhood Center that has been serving Billings since 1957. Because we are a non-profit, we rely on donations to help us run our programs and serve our community. By enrolling your children in our programming, you are joining our community. The larger Billings community supports our programming with grants, donations and volunteerism. Indeed, actual costs for Friendship House programming are in excess of $1,000 per month, per child. Thankfully, these costs are offset by the generosity of our community and every child receives scholarship assistance.

In order to provide quality programming and to have families committed to help their children grow to their potential, we ask all families who participate in our programs to join our community and donate to Friendship House to maintain our programming. We ask that families' donations are commensurate to the services received by that family. In the spirit of community and support for the value of the services provided, we offer the following suggested donations.

Youth Programming (Kindergarten-7th grade):
We are asking for a $_____ donation per month, based on your income.

As such, you will be sent a donation request each month. As a part of our community, we would ask you to honor your commitment to provide the best possible care for your children and families by submitting your requested donations to the office.

Because of the generous support of the community and your contribution, Friendship House staff will be able to provide the best possible care and training for your children.

I agree to this Covenant of Donation Support:

Parent/Guardian Signature_____
Printed Name _____
Date _____

We are excited to offer the safety, convenience and ease of Tuition Express®—a donation processing system that allows secure, on-time donations to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT or CREDIT CARD

I (we) hereby authorize (business name) FRIENDSHIP HOUSE OF CHRISTIAN SERVICE to initiate credit card charges to the below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, indicated below **(Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

CHOOSE A PULL DATE FROM THE 6TH OF THE MONTH TO THE 26TH _____

COMPLETE ONE SECTION ONLY

DO NOT USE DEBIT CARDS.
IF YOU DON'T HAVE CHECKS, PLEASE GET ROUTING NUMBER AND ACCOUNT NUMBER FROM YOUR BANK AND COMPLETE THE ACCOUNT SECTION BELOW.

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____

For Official Use Only

Date Received
Employee Signature

A service of

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FRIENDSHIP HOUSE
OF CHRISTIAN SERVICE

Scholarship Application

Application is for: ☐ *Summer* ☐ *School Year* ☐ *Preschool*

3 REQUIRED ATTACHMENTS
Application will not be considered unless copies of all documents are attached.

1. **TWO (2) most recent pay stubs for ALL household members**
2. **Most recent federal tax return filed for ALL household members** (please redact Social Security Number prior to submitting)
3. **Best Beginnings denial letter**

FRIENDSHIP HOUSE SCHOLARSHIP PARENT REQUIREMENT: All parents are required to volunteer 1-hour per month (per child) or attend 1-hour of adult education programming per month (per child).

Name: _____ **Phone:** _____

Child(ren):

NAME	AGE	RELATIONSHIP TO YOU

How many people live in your household? _____ **For each occupant of your household, provide name, relationship (to you), gross amount of income (with income frequency):**

NAME	RELATIONSHIP TO YOU	GROSS INCOME	INCOME FREQUENCY

How long have you been with Friendship House? _____

Friendship House Scholarship Application

Please explain why your family needs a Friendship House Scholarship:

Friendship House's extensive programming is heavily supported by community donors, grantors, and partners. Actual costs exceed $1,000.00 per month per child. Your monthly donation amount covers only a portion of this expense. Every family attending Friendship House already receives a substantial scholarship.

The state's Best Beginnings calculation formulas will be used to determine your monthly donation amount.

FALSE STATEMENTS, MISREPRESENTATION, AND FRAUD

Friendship House of Christian Service reserves the right to terminate an application, and/or revoke an awarded scholarship on the basis of false statements, misrepresentations, or other fraudulent declarations provided in this application regarding a level of financial need with the purpose of attaining a Friendship House Scholarship. It also reserves the right to take additional steps as deemed appropriate in instances where a scholarship has been awarded on the basis of misleading or fraudulent information.

By affixing my signature below, I CERTIFY the following:

1. **The information I provided in this application is true and accurate.**
2. **I understand that if any information within this application is found to be untruthful, incomplete, or inaccurate, the application will be considered null and void.**
3. **I understand that scholarship amounts are based on the donations Friendship House receives; thus awards will be granted permitted by available funding.**
4. **I understand that completing this application does not guarantee or entitle me to a Friendship House Scholarship.**

Printed Name: _____ **Signature:** _____

Date Signed: _____