FRIENDSHIP HOUSE
OF CHRISTIAN SERVICE

PRESCHOOL PROGRAM
FALL 2025

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. **For returning applicants:** Bill paid in full from previous enrollment
3. Enrolled with Express Pay Online
4. The following items brought to Friendship House:
   a. Registration fee of $30 per family, **must be paid before starting.**
   b. This packet, **fully completed**
   c. A copy of your child's **current immunizations** (you can have them faxed to 406-545-4901)
   d. Copy of your child's **insurance/Medicaid card**

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

PRESCHOOL PROGRAM
FALL 2025
ENROLLMENT INFO
REGISTRATION FORMS

Child's First Name:_____ Child's Last Name: _____

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

How old will your child be on August 24, 2025

☐ 3 Years Old ☐ 4 Years Old ☐ 5 Years Old

Does your child have any disabilities or special needs Friendship House staff should be aware of?

_____

_____

_____

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 11/19)

NON-INGESTIBLE OVER THE COUNTER MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT

Child's Name_____ Date of Birth____/____/____

Program Name _____

****

I give permission for the administration of the 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 medication:

- The medication must be brought to the day care facility from the parent;
- The 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? ____

Parent/Guardian Signature (required)_____ Date: ____/____/____

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

Unused Medication: (check one) Returned to Parent Y☐ N☐ Discarded appropriately Y☐ N☐

By: _____ **Date:** ____/____/____

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

FRIENDSHIP HOUSE
OF CHRISTIAN SERVICE

Name: _____

Age_____ **Grade**_____

Gender_____

PLEASE SIZE UP- these items will be given the week before Christmas Break.

- **Shirt Size (Y) (A)** _____
- **Pant Size(Y) (A)** _____
- **Dress Size (girls) (Y) (A)** ____
- **Bra Size(Y) (A)** _____
- **Under Pant Size (Y) (A)** _____
- **Sock Size(Y) (A)** _____
- **Shoe Size(Y) (A)** _____
- **Coat Size(Y) (A)** _____
- **Snow Pant Size(Y) (A)** _____
- **Boot Size(Y) (A)** _____

- **Please mark if things are Youth (Y) or Adult (A) Sizes.**
- **Size UP since these items will be coming just before Christmas.**
- **Please circle the items most needed this year for the child. IE, if the child has a coat from last year that still fits well and is still in good condition, but is wearing worn out socks and underwear, circle socks and underwear. This will help the person shopping for the child to prioritize what is most needed!**
- **Does the child have special interests? Favorite color/animal/sport/activity?**_____

_____

_____

_____

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
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

Child and Adult Care Food Program (CACFP) Enrollment Income Eligibility Application (EIEA)

PART 1 – CHILDREN'S INFORMATION (REQUIRED)

Child's Name	Birthdate	Age	Check Days of Attendance	Arrival Time	Departure Time	Check Meals and Snacks Normally Received	Check Below if Foster Child
			☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat			☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper ☐ Eve. Snack	☐
			☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat			☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper ☐ Eve. Snack	☐
			☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat			☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper ☐ Eve. Snack	☐
			☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat			☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper ☐ Eve. Snack	☐

PART 2 – HOUSEHOLD MEMBER RECEIVING BASIC FOOD/TANF/FDPIR IN WA STATE - Any household member receiving benefits can establish eligibility for children in the household. If you list a case number or ID, please skip to part 5.

Case Number or ID number:

PART 3 – TOTAL HOUSEHOLD GROSS ANNUAL INCOME

The adult signing the form must list the last four digits of their Social Security Number (SSN) or check the box if no SSN. *See Privacy Act Statement and Sources of Income on the back of this page*

(Annual Income Conversion by pay frequency: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12)

List names (First and Last) of people in your household	Check if no income	Annual Earnings from Work Before Deductions	Annual Welfare, Alimony, Child Support	Retirement, Pensions, Social Security, Other
1.	☐	$ /yr	$ /yr	$ /yr
2.	☐	$ /yr	$ /yr	$ /yr
3.	☐	$ /yr	$ /yr	$ /yr
4.	☐	$ /yr	$ /yr	$ /yr
5.	☐	$ /yr	$ /yr	$ /yr

☐ **I Decline to provide information about my household size and income.**

Number of total Household Members		Last 4 of SSN **(check box if no SSN)** ☐	

PART 4 – CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

We are required to ask for information about your children's race and ethnicity. This information helps to make sure we are fully serving our community. Responding to this section is optional, it will not affect your children's eligibility for receiving meals during care.

Ethnicity (check one):
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (check one or more):
- ☐ American Indian or Alaskan Native
- ☐ Multi-Racial
- ☐ Native Hawaiian or Pacific Island
- ☐ Black or African American
- ☐ Asian
- ☐ White

PART 5 – PARENT/GUARDIAN SIGNATURE AND CERTIFICATION—(REQUIRED) SIGNATURE CONFIRMS ALL INFORMATION PROVIDED IS CORRECT AND ACCURATE

"I certify (promise) that all information on this application is true, and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Signature ______________ Print Name ______________ Date ________

Address: City, State, Zip: Phone Number:

DO NOT FILL OUT – CENTER USE ONLY	CATEGORY		MT CACFP USE ONLY
______________ Institution Representative Signature ________ Date **INVALID WITHOUT SIGNATURE AND DATE** (see back for effective date requirements)	☐ Free (Basic Food/TANF/FDPIR) ☐ Free (foster child(ren)	Total Annual Income $________ ☐ Free ☐ Reduced ☐ Paid	☐ Free ☐ Reduced ☐ Paid ________ MT CACFP Rep.

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, the funds your childcare center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Basic Food, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child 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 the meal reimbursement for your childcare center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with federal civil rights law and USDA civil rights regulations and policies, the USDA, its agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint 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:

MAIL*: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or

FAX: (833) 256-1665 or (202) 690-7442; or
EMAIL: program.intake@usda.gov

***Only use this address if you are filing a complaint of discrimination.**

This institution is an equal opportunity provider.

****EIEA Effective Date****

***If the institution uses the parent/guardian signature date as the effective date, the form must be signed by the institution representative within the same month as the parent, or the following month. If the institution representative does not sign the EIEA within these timeframes, the institution representative's signature date must be used as the effective date.**

Valid TANF or Basic Food Number Guidelines and Contact Resources for MT State Recipients

Consists of six to seven digits, such as 4235555 Does not include any letters Is not a social security number (unless it's a tribal case number)	Does not start with a 200 series number Is not a case number for state-paid childcare Is not an EBT card number
MT DPHHS Public Assistance Customer Service Number: (888) 706-1535	**Basic Food and TANF website: www.apply.mt.gov**

Earnings from Work	Public Assistance, Alimony, Child Support	Pension, Retirement, Other Sources of Income	Sources of Child Income	Examples:
• Salary, wages, cash bonuses • Net income from self-employment (farm or business) If you are in the U.S. Military: • Basic pay and cash bonuses (do **NOT** include combat pay, FSSA, or privatized housing allowances) • Allowances for off-base housing, food, and clothing	• Unemployment benefits • Workers' compensation • Supplemental Security Income • Cash assistance from State or local government • Alimony payments • Child support payments • Veterans' benefits • Strike benefits	• Social Security (including railroad retirement and black lung benefits) • Private Pensions or Disability Benefits • Income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • Regular cash payments from outside household	Earnings from work	A child of legal working age has a regular full or part-time job where they earn a salary or wages
			Social Security -Disability Payments -Survivors Benefits	• A child is blind or disabled and receives Social Security benefits • A parent is disabled, retired, or deceased, and their child receives Social Security benefits
			Income from any other source	A child receives regular income from a private pension fund, annuity, or trust

FRIENDSHIP HOUSE
OF CHRISTIAN SERVICE

Payment Agreement Form Preschool 2024

Friendship House administrative reimbursement fee invoices are printed at the beginning of every month. Responsible payers must make sure monies are available for your chosen pull date from the 6th-26th of the month. Failure to pay or make arrangements before your pull date will result in a 10% Late Payment Fee. If an arrangement has not been made, your child(ren) will be exited from the program.

We require that students attend Friendship House programs **a minimum of four 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. Failure to inform FH of your child's absence will result in a No Call No Show (NCNS) charge of $5.00 per day per child charge on your account. These charges will be posted and charges pulled within 48hrs. Late pick up (after 5:30PM) will result in $10 per child charge that must be paid before the child returns to our care.

Friendship House has a $30.00 Non-refundable REGISTRATION fee per family. This MUST be paid at time of registration.

All Co-Pays for the HRDC Best Beginnings Scholarship must be paid in full by the last day of the month. Failure to do so will result in closure of your Best Beginnings Scholarship. You will also be charged the State Daycare Rates to cover our administrative reimbursement fee for that month (which is significantly higher than Best Beginnings Scholarship Co-Pay). If your Best Beginnings Scholarship ends, your account will be charged State Daycare Rates.

Please list your children who are enrolled with Friendship House.

_____ _____ _____ _____

_____ _____ _____ _____

- $25.00 (0-5 hrs/day) or $55.00 (over 5 hrs/day) State Childcare Rates for children in Preschool. $25.00 a day for less than 5hrs, $50.00 a day for more than 5hrs for children in the Youth program. *These rates are subject to change in accordance with changing State of Montana childcare rates.*
- **Best Beginnings Scholarship through HRDC.**
  Please inform Case Manager that your preschool child is at **PV 76060 Friendship House** Otherwise, full rates will apply.
  Please provide your HRDC Case Manager Name: _____
- **Friendship House Scholarship**(must apply & qualify)$ _____per month.
  Recipients will be responsible for _____ hours per child in program of either volunteer service hours or attending adult education classes at Friendship House.

By signing below, I acknowledge that I am responsible for paying monthly tuition to Friendship House and abide by the terms listed above. I understand that if I do not make my payment, my child will be exited from the program.

Payer Signature:_____ Date: _____

Payer Name Printed: _____

FH Admin Signature: _____ Date: _____

Tuition® Express

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments 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

procare SOFTWARE®

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 payment 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 payment 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: _____