

PART B: ENROLLMENT FORM FOR PARENT/CARETAKER FOR LEGALLY EXEMPT GROUP CHILD CARE PROGRAM

Part B must be completed by the parent/caretaker enrolling his/her child(ren) receiving assistance in a legally exempt group child care program.

SECTION 1: Program Information

Program Information			Enrollment Number (if known)				
Child Care Program's Legal Name:		ASSOCIATED BETH RIVKAH SCHOOLS		665852			
Site Address: Street Address	470 LEFFERTS AVENUE	Apt/FI #	City	State	Zip Code	County	
			BROOKLYN	NY	11225	KINGS	

SECTION 2: Parent/Caretaker Information

Parent/Caretaker Information:							
Name: First		Last (Please include any ALIASES or MAIDEN names in parentheses.)				MI	Suffix
Date of Birth	/	Gender	Home Phone	()	Work Phone	()	
Cell Phone	()		Email Address				
Home Address: Street Address			Apt /FI #	City	State	Zip Code	County
Mailing Address: Street Address/P.O. Box	<input type="checkbox"/> Same as above		Apt/FI #	City	State	Zip Code	County
Child Care Assistance Paying District:	BROOKLYN		Preferred Language	ENGLISH			

(For Enrollment Agency Use)

Received Date: / /	Completed Date: / /
CCFS ID:	Facility Name:

SECTION 3: Children Receiving Child Care Assistance

Child's Information			
Name, First:	Last:	MI:	Gender:
			F
Who will be responsible for meals/snacks? (Check one.)		Who will administer medication? (Check one.)	
<input checked="" type="checkbox"/> Program <input type="checkbox"/> Parent		<input type="checkbox"/> Program (must meet requirements as stated in the instructions) <input checked="" type="checkbox"/> Parent	

Child's Information			
Name, First:	Last:	MI:	Gender:
			F
Who will be responsible for meals/snacks? (Check one.)		Who will administer medication? (Check one.)	
<input checked="" type="checkbox"/> Program <input type="checkbox"/> Parent		<input type="checkbox"/> Program (must meet requirements as stated in the instructions) <input checked="" type="checkbox"/> Parent	

Child's Information			
Name, First:	Last:	MI:	Gender:
			F
Who will be responsible for meals/snacks? (Check one.)		Who will administer medication? (Check one.)	
<input checked="" type="checkbox"/> Program <input type="checkbox"/> Parent		<input type="checkbox"/> Program (must meet requirements as stated in the instructions) <input checked="" type="checkbox"/> Parent	

Child's Information			
Name, First:	Last:	MI:	Gender:
			F
Who will be responsible for meals/snacks? (Check one.)		Who will administer medication? (Check one.)	
<input checked="" type="checkbox"/> Program <input type="checkbox"/> Parent		<input type="checkbox"/> Program (must meet requirements as stated in the instructions) <input checked="" type="checkbox"/> Parent	

Child's Information			
Name, First:	Last:	MI:	Gender:
			F
Who will be responsible for meals/snacks? (Check one.)		Who will administer medication? (Check one.)	
<input checked="" type="checkbox"/> Program <input type="checkbox"/> Parent		<input type="checkbox"/> Program (must meet requirements as stated in the instructions) <input checked="" type="checkbox"/> Parent	

SECTION 4: Parent/Caretaker Certification

To the best of my knowledge, I hereby affirm that the information provided on *Part B* of this form is true and complete. I understand that the information is subject to verification and that making a materially false statement or affirmation may result in denial or termination of the enrollment, social services termination and child care assistance payments, and/or legal action against the parent/caretaker for deliberately presenting false or misleading information.

Signature of Parent/Caretaker:

Date:

/ /

SECTION 5: On-Site Director Certification

I hereby affirm that I have reviewed *Part B* of this form, and that to the best of my knowledge, the information provided on this form is true and complete. I understand that the information is subject to verification and that making a materially false statement or affirmation may result in denial or termination of the enrollment for deliberately presenting false or misleading information.

Signature of On-Site Director:

Date:

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