After School Programming

Afternoons full of fun, a lifetime of memories!

After School Programming provided by The Children's Home of Cincinnati is a fun filled and academically enriching program for children ages 5-12 years. The programs offer educational support and a safe, structured environment after the school day ends, along with recreational opportunities, wellness activities, mental health interventions, and family programs.

The weekly activities are linked to the Ohio Department of Education's Common Core Content Standards. The program offers a safe, stimulating environment designed to enhance creativity, promote leadership and social skills, and celebrate culture and diversity. In addition, after school enjoys field trips, guest speakers, weekly themed activities, and much more!

Licensing and Accreditation Bodies:

All School Age Programs are licensed by the Ohio Department of Job and Family Services and the City of Cincinnati. We are also accredited by the Council on Accreditation.

After School Capacity:

Each After School Program is licensed to meet demand, a total number of children served daily at your program can be found on the Child Care License located in After School Office at your site.

Eligibility:

Children ages 5-12 years are eligible for enrollment. Children must be enrolled Kindergarten.

After School Dates:

Monday-Friday August 15, 2018 — May 23, 2019

The programs observe all closings of Cincinnati Public Schools.

After School Hours: 2:15 PM – 6:00 PM

Meals/Snacks: An afternoon snack and dinner service are provided daily.

Staff to Child Ratios and Group Size:

We strive to keep our ratios below State Standards.

School Age Children- 1:15, maximum group size of 36

Weekly Tuition:

$65.00 a week, the tuition rates apply to all age groups between 5 and 12. Private Fee Pay or Child Care Vouchers are accepted.

Enrollment:

Completed enrollment application packet must be returned in envelope provided with all requested items.

After School Programming Locations:

Midway Elementary, Mt. Washington, and Silverton Paideia

For More Information please contact:

Beth Wiseman, School Age Services Manager at 513-272-2800 or your school's After School Site Lead.

The Children's Home of Cincinnati General Information

Child's Name: _____ Start Date: _____

Gender: _____ Race: _____ Age:_____

Grade: _____ Teacher:_____

Participating School: **(please circle one)**

Midway Elementary Silverton Paideia Mt. Washington

Anticipated Schedule:

Full Time (Monday-Friday)

Part Time Please circle the days that your child will be attending the program.

M T W R F

Payment Method

Private Pay Hamilton County Vouchers Case #_____

When do you need care to begin? _____ (Date)

What are your hopes for your child and family in this program?

_____

What are your expectations for our program?

_____

Child's History

Does your child, or your household, have a second language? _____

Do you have any concerns about your child's learning, please include subjects they find difficult?

_____

Does your child have or ever had any of the following? Please check YES or NO for each item.

Mental Health Diagnosis	YES	NO	Education Disabilities	YES	NO
ADHD			Autism Spectrum Disorder		
Attachment Disorder			Cognitive Development		
Bipolar			Emotional Disturbances		
Conduct Disorder			Hearing Impairment		
Emotional Disturbances			Learning Disability		
Mood Disorder			Multiple Handicapped		
ODD			Visual Impairment		
Other:			Down Syndrome		

If "YES" to any condition or disease listed, please explain:

_____

_____

Please check ALL of the words that best describe your child's personality and behavior:

☐ active ☐ adventurous ☐ affectionate ☐ anxious ☐ bossy ☐ bright ☐ busy ☐ calm ☐ cautious ☐ cheerful ☐ content ☐ creative ☐ curious ☐ easily-angered ☐ emotional ☐ energetic ☐ excitable ☐ friendly ☐ gives-in-easily ☐ happy ☐ hesitant ☐ insecure ☐ jealous ☐ likes structure/routines ☐ loud ☐ loving ☐ mellow ☐ outgoing ☐ prefers adult attention ☐ quiet ☐ sensitive ☐ serious ☐ shares-well ☐ social ☐ spontaneous ☐ stubborn ☐ tentative ☐ other:

_____

Diet/Nutrition History

Does child have any dietary restrictions? _____NO _____ YES Please list:

_____

Are there foods you child is not allowed to eat due to religious reasons? NO YES Please list:

_____

Does child have an outside area to play? _____ NO _____ YES

What are your child's favorite foods?_____

Foods your child dislikes _____

Social History

Does your child prefer to play: alone ____, with playmates____, with sibling(s)____ with adults____

What are your child's favorite indoor/outdoor activities?

_____

Is there anything else we should know about your child?

_____

Guidance & Behavior

Would you judge your child to be: easily managed ____ fairly easily managed____ difficult to manage ____

Are there any circumstances in the family which may be a factor in your child's present behavior (divorce, death, new baby, recent move, hospitalization, etc.): _____

When your child is frustrated (mad), what happens? _____

What makes your child frustrated (mad)? _____

What routines/actions or items do you use to comfort your child?

_____

What methods do you use to respond to your child's negative behavior?

_____

Does your child have any particular fears? _____

Family Culture

How would you like us to recognize your child ethnically? _____

Who is in the child's immediate family? _____

Who lives at the home with your child? _____

What family traditions would you like our program to acknowledge? _____

What can we learn about your culture to help us be as respectful as possible? _____

Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.?

_____

What holidays do you celebrate? _____

Do you have any pets at home? If so, what are they and what are their names? _____

Special Needs

Does your child have a special need because of a disabling or limiting condition? If yes, please describe:

_____

_____

Getting to Know my Child

Thank you for choosing the Children's Home of Cincinnati's Afterschool Program. In order to ensure that your child has a positive experience with us, we are asking that you provide the information below regarding your child's strengths, needs and preferences. This will help ensure that we are prepared in advance to meet your child's needs. (Please fill out one form per child.)

Name and age of child:_____

Has your ever attended an Afterschool Program? Yes or No

If yes, where and how did your child respond to being at camp?_____

_____

_____

Likes or Dislikes	Please describe your child's likes or dislikes in space provided:
Favorite activities	
Favorite toys/games	
Favorite foods	
Strong dislikes:	

Friendships Please rate the following statements regarding your child's interactions with other children:	Never	Some of the time: 1x -2x a month	Often: 1x -2x a week	Most of the time: daily	Not Sure
Is liked by other children and makes friends easily	0	1	2	3	NA
Engages other children in conversation or play	0	1	2	3	NA
Shares and respects belongings of other children	0	1	2	3	NA
Maintains good physical space with other children	0	1	2	3	NA
Argues with other children	0	1	2	3	NA
Blames others for mistakes or misbehaviors	0	1	2	3	NA
Is touchy or easily annoyed by others	0	1	2	3	NA
Physically fights with other children	0	1	2	3	NA
Bullies, threatens or intimidates others	0	1	2	3	NA
Please add any additional information about your child's interactions with other children:					

Relationships with Adults Please rate the following statements regarding your child's interactions with adults:	Never	Some of the time: 1x -2x a month	Often: 1x -2x a week	Most of the time: daily	Not Sure
Is trusting of adults	0	1	2	3	NA
Asks adults for help or for what is needed	0	1	2	3	NA
Follows directions	0	1	2	3	NA
Argues with adults	0	1	2	3	NA
Lies to get out of trouble	0	1	2	3	NA
Pushes, kicks or hits adults when angry	0	1	2	3	NA
Please add any additional information about your child's interactions with adults:					
What can we do to make sure we form a positive relationship with your child?					

Self-Control Please rate the following statements regarding your child's abilities to manage behaviors:	Never	Some of the time: 1x -2x a month	Often: 1x -2x a week	Most of the time: daily	Not Sure
Is able to name and talk about feelings	0	1	2	3	NA
Is able to wait and take turns	0	1	2	3	NA
Participates in quiet activities or independent play	0	1	2	3	NA
Becomes easily frustrated and gives up	0	1	2	3	NA
Throws or destroys things when angry	0	1	2	3	NA
Loses temper	0	1	2	3	NA
Are their specific events or triggers that lead to certain behaviors?					
How do you handle these behaviors?					
In what ways will your child need specialized assistance from the counselor's?					

Ohio Department of Jobs and Family Services

CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name	Date of Birth	First Day at Program/Home
Home Address	City	
State	Zip	Home Telephone Number
Parent/Guardian Name	Relationship to Child	
Home Address	Home Telephone Number	
City	State	Zip
Email Address (If applicable)	Cell Phone	
Parent's Work/School Telephone Number	Parent's Work/School Name	
Parent's Work/School Address	City	

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians.
☐ Yes ☐ No If you answered yes, please indicate which number(s) above to include on the list: ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Parent/Guardian Name	Relationship to Child	
Home Address	Home Telephone Number	
City	State	Zip
Email Address (If applicable)	Cell Phone	
Parent's Work/School Telephone Number	Parent's Work/School Name	
Parent's Work/School Address	City	

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians.
☐ Yes ☐ No If you answered yes, please indicate which number(s) above to include on the list: ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Emergency Contacts: Parents **cannot be listed** as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness **if you cannot be reached**. Any person listed should be able to assist in contacting you. At least one person listed must be within one hour of the center/home, able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

Name		Name	
City	State	City	State
Telephone	Relationship to Child	Telephone	Relationship to Child
Other numbers where emergency contact can be reached (if applicable)		Other numbers where emergency contact can be reached (if applicable)	

Name of Physician or Clinic/Hospital		
Street Address		
City	State	Telephone Number

Child's Name

Allergies, Special Health or Medical Conditions, and Food Supplements

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be

Does your child have any food, medication or environmental allergies? (check all that apply)

☐ No

☐ Yes - Check all that apply ☐ Food ☐ Medication ☐ Environment Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms, take action if a reaction occurs, or give emergency medication to your child? (check one)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Does your child have a special health or medical condition? (check one)

☐ No

☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (check one)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? (check one)

☐ No

☐ Yes - please explain

If yes, does this medication, food supplement, or medical food need to be administered at the child care center/type A home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.

☐ N/A - program does not administer any medications.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (check one)

☐ No

☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

☐ No

☐ Yes - written instructions from the child's health care provider must be on the JFS 01217 "Request for Administration of Medication."

☐ N/A - child does not attend a full time program.

Child's Name
List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff **or medical personnel** in an emergency situation.
List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page.

Diapering Statement

Is your child toilet trained? ☐ Yes (If yes, skip to Emergency Transportation Authorization section) ☐ No (If no, fill out the following)

The program's policy is to check diapers every _____ according to the program's policy or another:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

Give *Permission* to Transport		***Do Not Give Permission* to Transport**
Program or Home Name	**OR** **Do not sign both**	Program or Home Name
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.		does not have permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:
Parent Signature		Parent Signature
Date		Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. ☐ Yes ☐ No

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note: This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15 and 5101:2-13-15. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

Ohio Department of Jobs and Family Services

CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE

Child's Name	Date of Birth
Special Health Conditions	
Symptoms to watch for and emergency action to be taken if the following symptoms occur	
Activities/foods/environmental conditions to avoid, if applicable	
Medical procedures to be followed and expected benefit of treatment, if applicable	
Are any medications required? ☐ Yes ☐ No *(If yes, complete JFS 01217 Request for Administration of Medication)* If yes, what medications?	
In an emergency does this child require additional assistance (more than other children of the same age or in the same group) to evacuate? ☐ Yes ☐ No	
In the event that the child care program must be evacuated, are there medications or supplies that must be taken with this child? ☐ Yes ☐ No	
Training Instructions *(Trainer must be a parent or certified professional)*	
Signature of Trainer	Date

Signature of trained providers, substitutes or child care staff members who have been made aware of the condition.

(There must always be a trained caregiver present when the child is present)

Signature	Date	I have been ☐ informed	I have been ☐ trained
Signature	Date	I have been ☐ informed	I have been ☐ trained
Signature	Date	I have been ☐ informed	I have been ☐ trained
Signature	Date	I have been ☐ informed	I have been ☐ trained

(Only trained providers, substitutes or child care staff members shall be permitted to perform medical procedures listed above.)

Additional services (educational/therapeutic) child is receiving

Who provides the above services?

Name	Phone Number	May we contact? ☐ Yes ☐ No
Name	Phone Number	May we contact? ☐ Yes ☐ No

I give my permission for the staff listed above to perform the procedures in my child's Medical/Physical Care Plan.

Parent Signature	Date
Administrator/Provider Signature	Date

Note: A separate plan must be written for each condition that requires different actions to be taken

Ohio Department of Jobs and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

Box 1	The following section must always be completed by the parent/guardian.

Check all that apply and complete all of the information.

☐ Prescription Medication ☐ Nonprescription Medication ☐ Food Supplement ☐ Topical Product or Lotion

☐ Refrigeration Required ☐ Modified Diet

Name of Child	Date of Birth	Weight

Name of Medication	Exact Dosage
To be administered at the following times	For the following period of time

☐ I understand that my child must receive one dose of medication before arriving at the program (unless the medication is used for emergencies.

Parent Signature	Date

Box 2	The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant.

1. The medication contains codeine or aspirin.

2. A physician's instruction is needed for a nonprescription medication (e.g. child does not meet minimum age or weight requirements as listed on the label instructions).

3. It is a sample medication without a prescription label.

4. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period.

5. The topical product or lotion and the physician's instructions exceed the manufacturer's instructions or use.

Name of Child	Name of medication, vitamin, diet, supplement
Dosage	Possible side effects to watch for are

Expiration date

(May not exceed twelve months from the date of this request for medications of food supplements).

Instructions

This child is under my care and should receive the above medication as written.

Signature of physician, dentist, advanced practice registered nurse or certified physician's assistant

Date of signature	Phone Number
Name of Child	Name of medication, vitamin, diet, supplement

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

Box 3	The following section must be completed by the center, family child care provider or in-home aide for the child listed on page one of this form. All medication must be documented when administered.

Date	Time	Dosage	Signature of Designated Person Administering Medication

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

Authorization for Pick Up and Emergency Contacts

Child's Name: _____

Each day when my child is brought to The Children's Home of Cincinnati After School Program, he/she will be escorted to the appropriate classroom and left in the care of a staff person.

The Individuals listed below are authorized to pick up my child or to assume responsibility for my child in case of an emergency, accident, or illness. If none of the people listed are available, I give permission to The Children's Home of Cincinnati After School Program staff to make a plan for the care of my child.

Please list any information regarding custody arrangements/restraining orders (persons who may not visit or take your child under any circumstances) or indicate if this does not apply by writing N/A on the lines below.

_____ _____

Signature of Parent/Guardian Date

Authorized Pick Up and Emergency Contacts

Please list Parent/Guardian first and **2 people other than parent**.

_____ _____

Name Relationship

_____ _____ _____

Home Telephone Work Telephone Cell Phone

_____ _____

Name Relationship

_____ _____ _____

Home Telephone Work Telephone Cell Phone

_____ _____

Name Relationship

_____ _____ _____

Home Telephone Work Telephone Cell Phone

_____ _____

Name Relationship

_____ _____ _____

Home Telephone Work Telephone Cell Phone

Informed Consent and Permission to Provide Services

I (we), _____, give my (our) child(ren) and/or family receive services from the staff of THE CHILDREN'S HOME OF CINCINNATI, OHIO.

I (we) have received an explanation of the proposed **THE CHILDREN'S HOME SCHOOL AGE PROGRAM** service. I (we) understand that I (we) have the right to refuse this service or withdraw my (our) consent for service at any time.

I (we) understand that information obtained during the course of service is privileged and confidential and may not be release without my (our) written consent, except in the following situations:

If staff has reason to suspect of have knowledge of abuse or neglect, THE CHILDREN'S HOME OF CINCINNATI is obligated by the State of Ohio to report that knowledge or suspicion to the children's protective services;

If staff have reason to believe that a client is homicidal or suicidal, THE CHILDREN'S HOME OF CINCINNATI reserves the right to take protective action and notify the police or potential victims;

If referral sources of Hamilton County Juvenile Court requires reports from THE CHILDREN'S HOME OF CINCINNATI; and

If you should have any questions or concerns, please talk with your assigned staff person. If you are not satisfied with the response, you may contact Program Manager, the Service Director, or the Client Rights Officer.

_____ _____

Parent/Guardian Signature Date

Participate in the Evaluation of The Children's Home School Age Program

Dear Parent,

Your Child_____ is enrolled in the afterschool program with The Children's Home of Cincinnati (CHOC). In order to monitor the effectiveness of the program and ensure its future success, The Children's Home of Cincinnati is conducting an ongoing evaluation. It is the intention of the evaluation to learn how these services help students and how they can be improved in order to meet funding, licensing, and accreditation requirements.

Specifically we ask permission from parents to:

- Talk to teachers and afterschool staff about children's progress and participation in the program, and review program records on participation in the program.
- Conduct surveys, developmental screenings, and interviews with the parents and children about the program and its effects.

Any information we collect will only be used to assess the afterschool program and will not be made public. Participating in the evaluation will not affect your child in the afterschool program or in any other way. We will not use your name or your child's name in any report. We are looking at data as a whole, not on an individual level. At the end of the evaluation, we will destroy all records that include personal information. Participation in the study is completely voluntary and participants may withdraw at any time with no consequences.

Please select one of the options below and return this form to the program coordinator/ director.

☐ *YES, I GIVE PERMISSION FOR MY CHILD TO PARTICIPATE. I have read the above information and I give permission for my child to participate in the evaluation of the afterschool program. I also consent for CHOC to obtain for my child's records and school staff for evaluation purpose.*

☐ *NO, I DON NOT WANT MY CHILD TO PARTICIPATE. I have read the above information and I **DO NOT** give permission for my child to participate in the evaluation of the afterschool program.* If you have any questions about the evaluation contact the After School Supervisor.

_____ _____

Parent/Guardian Signature Date

The Children's Home of Cincinnati Parent Agreement

Arrival and Departure

- Children must be signed out each day by the parent or person from authorized list to pick up the child.

Fees and Payments

- Tuition is due for the upcoming week of attendance by 6:00pm on Friday's. The program reserves the right to withdraw your child(ren) after 2 days of non-payment of tuition or if the account becomes delinquent. Cash, checks, credit cards, and money orders are acceptable forms of payment. **Please note that when paying with cash, we cannot give out change.**
- **If you wish to set up an alternative payment schedule please contact Sue Leach in Accounts Receivable at 272-2800 (ext 4505).**
- The parent or guardian whose name is on the billing record is ultimately and solely responsible for paying the balance due.
- Returned check fee is $30.
- Failure to pick up children by close of program (6:00 pm) will result in a charge of $5.00 for the first 10 minutes and $1.00 per minute thereafter for each child.
- Deductions will not be made for absences, including those due to illness or vacation.
- In order to start on August 15th packets are due by August 7th. Applications will be accepted as they are returned with a rolling start date no longer than 3-5 business days after the application is received.

Hamilton County Child Care Voucher Program

- **Full time students must attend at least 7.00 hours per week. An absence will be used to meet hours.**
- May not exceed 10 absences per 6 months (Jan.-June, July-Dec.). Absences incurred from your previous provider will carry into After School. Additional absences will result in the assessment of additional fees on the account, which will be due immediately. Parents are ultimately responsible for making sure that payments are made by third party sources. This includes but is not limited to co-pay discrepancies, authorization issues, re-eligibility delays, late voucher payments, and unauthorized days due to eligibility restrictions. Failure to do so may result in suspension and/or termination from the program.
- Parents must have voucher coverage on the 1st day of programming. A self-pay fee ($65.00 per week per child) will be billed until coverage is received. Billings will be adjusted only once voucher coverage is provided and back swipes have been completed for all days attended.
- Parents must swipe student(s) in and out on a daily basis. This is a condition of HCJFS' child care coverage, and failure to do so may result in HCJFS terminating child care voucher coverage. (NOTE: no staff member can complete swipes, per HCJFS' policy.)
- Attendance swipes must be completed by the "settlement deadline" date (two weeks from attendance date) a chargeback will be assessed at the family's expense (up to $65.00 per week). (NEW as of 5/4/14)
- In the event of an unpaid balance After School Programs reserve the right to file a delinquent voucher form with HCJFS.
- Program Specifics
- After School runs from 2:10 pm – 6:00 pm, Monday – Friday, following the Cincinnati Public School calendar.
- The programs will be closed on the following dates:

September 3	**September 17**	**October 22**	**November 6**
November 12	**November 21 - 23**		**December 24 - January 4**
January 14	**January 21**	**February 4**	**February 18**
March 22 – 29 (Spring Break)	**May 24**		

- Parents may voluntarily **withdraw** their child from the program by giving a minimum **three day written notice**. If notification is not received, a one week tuition fee will be assessed to the parent's account and will be due immediately.

I have read and understand the information above. I understand my rights and responsibilities regarding the attendance requirements. I further understand my financial obligations.

Parent/Guardian(s): _____ _____

Signature of financially responsible party Date

The Children's Home of Cincinnati Parent Agreement (Parent Copy)

Arrival and Departure

- Children must be signed out each day by the parent or person from authorized list to pick up the child.

Fees and Payments

- Tuition is due for the upcoming week of attendance by 6:00pm on Friday's. The program reserves the right to withdraw your child(ren) after 2 days of non-payment of tuition or if the account becomes delinquent. Cash, checks, credit cards, and money orders are acceptable forms of payment. **Please note that when paying with cash, we cannot give out change.**
- **If you wish to set up an alternative payment schedule please contact Sue Leach in Accounts Receivable at 272-2800 (ext 4505).**
- The parent or guardian whose name is on the billing record is ultimately and solely responsible for paying the balance due.
- Returned check fee is $30.
- Failure to pick up children by close of program (6:00 pm) will result in a charge of $5.00 for the first 10 minutes and $1.00 per minute thereafter for each child.
- Deductions will not be made for absences, including those due to illness or vacation.
- In order to start on August 15 th packets are due by August 7th. Applications will be accepted as they are returned with a rolling start date no longer than 3-5 business days after the application is received.

Hamilton County Child Care Voucher Program

- **Full time students must attend at least 7.00 hours per week. An absence will be used to meet hours.**
- May not exceed 10 absences per 6 months (Jan.-June, July-Dec.). Absences incurred from your previous provider will carry into After School. Additional absences will result in the assessment of additional fees on the account, which will be due immediately. Parents are ultimately responsible for making sure that payments are made by third party sources. This includes but is not limited to co-pay discrepancies, authorization issues, re-eligibility delays, late voucher payments, and unauthorized days due to eligibility restrictions. Failure to do so may result in suspension and/or termination from the program.
- Parents must have voucher coverage on the 1st day of programming. A self-pay fee ($65.00 per week per child) will be billed until coverage is received. Billings will be adjusted only once voucher coverage is provided and back swipes have been completed for all days attended.
- Parents must swipe student(s) in and out on a daily basis. This is a condition of HCJFS' child care coverage, and failure to do so may result in HCJFS terminating child care voucher coverage. (NOTE: no staff member can complete swipes, per HCJFS' policy.)
- Attendance swipes must be completed by the "settlement deadline" date (two weeks from attendance date) a chargeback will be assessed at the family's expense (up to $65.00 per week). (NEW as of 5/4/14)
- In the event of an unpaid balance After School Programs reserve the right to file a delinquent voucher form with HCJFS.
- Program Specifics
- After School runs from 2:10 pm – 6:00 pm, Monday – Friday, following the Cincinnati Public School calendar.
- The programs will be closed on the following dates:

September 3	**September 17**	**October 22**	**November 6**
November 12	**November 21 - 23**	**December 24- January 4**	
January 14	**January 21**	**February 4**	**February 18**
March 22 – 29 (Spring Break)	**May 24**		

- Parents may voluntarily **withdraw** their child from the program by giving a minimum **three day written notice**. If notification is not received, a one week tuition fee will be assessed to the parent's account and will be due immediately.

Authorization for Photographic, Cinematic, Voice Reproduction and/or Testimonials

This Authorization is based on the following conditions:

- It is for the above listed Materials only (not any clinical records or other information).
- Materials produced become the property of The Children's Home of Cincinnati.
- It is given without promise of compensation to you.
- The parent or legal guardian and child/client release to The Children's Home of Cincinnati any right, title, and/or interest of any kind they may have in the Material produced.
- Granting Authorization to The Children's Home is totally voluntary. If you do not grant Authorization, The Children's Home of Cincinnati will not deny any services or benefits to you/your child.

Authorization to Take, Use, or Disclose Photographic, Cinematic, and/or Voice Reproduction ('Materials')

☐ I **hereby grant** The Children's Home of Cincinnati ('CHOC') the right and authority to photograph, film, interview, and/or vocally record my child.

☐ I **do not grant** The Children's Home of Cincinnati ('CHOC') the right and authority to photograph, film, interview, and/or vocally record my child.

These Materials may then be used by CHOC for promotional, fundraising, or publicity purposes, and may be used in mass media publications, on the organization's websites and social media sites, televised, or used in film presentations. Media resources include, but are not limited to, newsletters, annual reports, brochures, professional publications, and special event/promotional materials. Unless I check the box, below, my child's and my family's names also may be disclosed. This Authorization is effective for 7 years after my child's last school year or service date at CHOC, unless revoked in writing by the undersigned. Such revocation can be made at any time, but will only be effective to prevent further use or disclosure of the Materials. Please note that, once CHOC discloses or publishes them, the Material could be re-disclosed by a recipient and may no longer be covered by any federal or Ohio privacy laws.

Authorization to Disclose Actual Name(s) in the Activities Listed Above

☐ CHOC **may** disclose actual name(s) in the activities listed above.

☐ CHOC **may not** disclose actual name(s) in the activities listed above.

_____ _____ _____

Name of Parent/Guardian | Signature of Parent/Guardian | Date

_____

Name of Client

Acknowledgement of Receipt of Parent Handbook

I, _____, acknowledge that I have received a copy of the Camp-I-Can Parent Handbook which contains the policies and guidelines for the program. I further acknowledge that I understand and agree to abide by the written policies set forth in the parent handbook. I understand that it is my responsibility to contact the Camp Supervisor with any questions I have about the information contained in this document.

_____ _____

Parent/Guardian Signature | Date

Notification and Consent for a Follow-Up Survey

I agree to be contacted after services have ended for the purposes of gathering transitional information. This information will be gathered by telephone with either you or your school district representative at 30 days, 180 days, and one year following discharge from Early Childhood Programs and Education Programs. The purpose of this information is to begin to develop some benchmarks for measuring the effectiveness of Early Childhood and Education Programs.

By signing below, I acknowledge the above information has been discussed with me and I understand the process. I also understand that I may choose at any time, not to participate in these surveys.

_____ _____

Parent/Guardian Signature | Date

The Children's Home of Cincinnati Client Rights Notice

We place high value on you, as a client of The Children's Home of Cincinnati, and pledge to respect your rights as listed below.

RIGHT	DESCRIPTION
1. The right to be treated with consideration and respect for personal dignity, autonomy, and privacy.	*You have the right to be free from physical abuse, sexual abuse, and emotional abuse. If you are not sure if it is abuse, ask your Client Rights Officer or someone you trust.*
2. The right to service in a humane setting which is the least restrictive feasible, as defined in the treatment plan.	*You can't be committed to a hospital or put in a quiet room unless there is no other treatment to help you to be safe to yourself and others. As soon as it is safe, you must be given more freedom.*
3. The right to be informed of one's own condition, of proposed or current services, treatments or therapies and the alternatives.	*Ask questions. You have the right to answers and the right to know what's going on.*
4. The right to consent to refuse any service, treatment, or therapy upon full explanation of the expected consequences of such consent or refusal. A parent or legal guardian may consent to or refuse any service, treatment or therapy on behalf of the child.	*Say yes when you mean yes and no when you mean no. A parent or guardian may do this on behalf of a child.*
5. The right to a current, written individualized service plan that addresses one's own mental health, physical health, social and economic needs, and that specifies the provision of appropriate and adequate services, as available, either directly or by referral.	*You must have a plan which meets your needs. It is your road map to getting on with life.*
6. The right to active and informed participation in the establishment, periodic review and reassessment of the service plan.	*You or a parent or guardian must be permitted to help create or change your plan.*
7. The right to freedom from unnecessary or excessive medication.	*Taking meds is your choice. If you refuse some or all of your meds, you don't lose other rights or services.*
8. The right to freedom from unnecessary restraint or seclusion.	*You can't be put in restraints or in a quiet room as punishment. This can happen only when you are out of control in a potentially dangerous way and other means to try to help you have failed. Outside the hospital, you can't be 'sent to your room' although you can be asked to leave a common area for a time.*
9. The right to participate in any appropriate and available agency service, regardless of refusal of one or more other services, treatments, or therapies, or regardless of relapse from earlier treatment in that or another service, unless there is a valid and specific necessity which precludes and/or requires the client's participation in other services. This necessity will be explained to the client and written in the case record.	*Services are like a submarine sandwich made especially for you. If you (or your parent/guardian) do not want the onions, you can still have the rest of the sandwich.*
10. The right to be informed of and refuse any unusual or hazardous treatment procedures.	*You (or your parent/guardian) must be told of special or risky treatments and make a decision not to have them.*
11. The right to be advised of and refuse observation by techniques such as one-way vision mirrors, tape recorders, movies or photographs.	*Nobody can take your picture or record you in a mental health setting without your (or your parent/guardian's) permission.*
12. The right to have the opportunity to consult with independent treatment specialists or legal counsel at one's own expense.	*You can have your own doctor, counselor or lawyer, but usually you must pay for it.*
13. The right to confidentiality of communications and of all identifying information within the limitations and requirements for disclosure of various funding and/or certifying sources, state or federal statutes, unless release of information is specifically authorized by the client, parent or legal guardian of the child.	*There are rules about who may see your records. These rules protect you from having people tell private information without your permission (or the permission of your parent/guardian).*
14. The right to file a grievance.	*If you are not satisfied with the outcome when you make a complaint, you may make your complaint formal by contacting the Client Rights Officer.*
15. The right to have oral and written instructions for filing a grievance.	*You will be helped if you want it in making this complaint formal.*

RIGHT	DESCRIPTION
16. The right to have access to one's own records, unless restricted by adoption statutes or there are clear treatment reasons for denying access. When access is denied to specific information, the treatment plan indicates what information is restricted and the reasons for the restriction. 'Acceptable reason for restriction' means that severe emotional damage will be done to the client, such that dangerous or self-injurious behavior is an eminent risk. The client or others authorized to have the information are informed about the restriction and the specific reasons for it. The restriction is valid for up to one year and thereafter must be re-issued with appropriate procedures followed. Any person authorized in writing by the client and professionally qualified to do so has unrestricted access to all information.	*You (or your parent/guardian) may see or get a copy of your own records in most cases. If you are denied the right to see your records, check with a Client Rights Officer to see if the denial is valid.*
17. The right to be informed in advance of the reason(s) for discontinuance of service provision, and to be involved in planning for the consequences of discontinuance.	*You cannot just be kicked out of a program or service. You must be told why and helped to find other service.*
18. The right to receive an explanation of reasons for denial of service.	*You must know why an agency will not serve you.*
19. The right not to be discriminated against in the provision of service on the basis of religion, race, color, creed, sex, national origin, age, lifestyle, physical or mental handicap, developmental disability, or ability to pay.	*Everyone is welcome. If you have special needs, they will be provided for.*
20. The right to know the cost of services.	*You or your parent/guardian must be told what, if anything, a service will cost. A parent/guardian will be asked to sign a fee agreement.*
21. The right to be fully informed of all rights.	*Your rights will be explained and you will be given a copy. If you lose it you may have another. If you like, your rights will be read to you.*
22. The right to exercise any and all rights without reprisal in any form including continued and uncompromised access to service.	*If you have a complaint, you can speak up without losing services.*

If you feel one or more of your rights has been infringed upon, you have a right to file a grievance with our Client Rights Officer:

Client Rights Officer
The Children's Home of Cincinnati
5050 Madison Road, Cincinnati, Ohio 45227

If you have any questions, please ask any staff member. You may also contact one or more of the following boards or government agencies:

Hamilton County Mental Health and
Recovery Services Board
2350 Auburn Ave, Cincinnati, OH 45219
(513) 946-8600; (513) 946-8610 (fax)
http://hcmhrsb.org/

State Board of Psychology
77 S. High St, Suite 1830, Columbus, OH 43215-6108
(877) 779-7446 (toll free); (614) 728-7081 (fax);

Ohio Department of Mental Health & Addiction Services
Client Advocacy Coordinator
30 E. Broad St, 8th Floor, Columbus, OH 43215-3430
(614) 466-2596; (877) 275-6364 (toll free)
www.mha.ohio.gov

Disability Rights Ohio
50 W. Broad St, Suite 1400; Columbus, OH 43215-5923
(614) 466-7264; (800) 282-9181 (toll free)
www.olrs.ohio.gov

U.S. Department of Health & Human Services
Office for Civil Rights - Region V
233 N. Michigan Ave, Suite 240, Chicago, IL 60601
(800) 368-1019 (toll free); (312) 886-1807 (fax)
www.hhs.gov/ocr/office

Ohio Board of Nursing
17 S. High St, Suite 400, Columbus, OH 43215-7410
(614) 466-3947; (614) 466-0388 (fax)
www.state.oh.us/nur

State of Ohio Counselor, Social Worker and
Marriage & Family Therapist Board
50 West Broad St, Suite 1075, Columbus, OH 43215-5919
(614) 466-0912; (614) 728-7790 (fax)
www.cswmft.ohio.gov

State Medical Board of Ohio
30 East Broad St, 3rd Floor, Columbus, OH 43215-6127
(614) 466-3934; (614) 728-5946 (fax); (800) 554-7717 (toll free)
http://med.ohio.gov/consumer.htm

The Children's Home of Cincinnati Grievance Procedure

The goal of the grievance procedure is to achieve fairness, dignity, opportunities for conciliation, and an atmosphere of mutual respect. It is the intent of the procedure that all clients are provided with access to someone who will hear their complaints fairly, should they choose to work on their concern through a formal process.

If your concern addresses alleged abuse or neglect, it is required that it be reported immediately to the Hamilton County Department of Human Services for its investigation.

The assigned primary service provider is your initial contact person within the agency. Any concerns you or a member of your family have about your care or your child's care can be addressed to the primary service provider at any time. If your concerns are not addressed to your satisfaction by the primary service provider, you may go to the Program Manager, and then to the Department Director.

If your concerns are not answered to your satisfaction by the program staff, you may contact the Client Rights Officer by calling (513) 272-2800 or writing to The Children's Home of Cincinnati, 5050 Madison Road, Cincinnati, Ohio 45227. The Client Rights Officer will assist you through the complaint process. You have the right to a representative for the entire grievance process or for any part of it. If you would like a representative but don't have anyone to call on, the Client Rights Officer will either serve as your representative or help identify someone who will represent your interests, as you see them, and who will make sure you have all of your questions answered.

If you choose to file a formal, written grievance, it will be reviewed within seventy-two hours by a member or members of the Quality Steering Team, or its designee. The reviewer(s) will assess the validity of your grievance, ascertain the facts in the situation, and discuss it with all parties involved. The reviewer(s) will then provide a resolution and an explanation in writing within twenty working days of the original filing. You may appeal to the President & CEO of The Children's Home and a response will be given within forty-eight hours of being received. The President & CEO will have final authority to evaluate and resolve the grievance. A copy of the agency response to the grievance will be placed in the client record.

There will be absolutely no reprisals against anyone making a complaint or filing a formal grievance. Filing a grievance will in no way have any bearing on the continuance of services to you, your child, or members of your family. We are interested in knowing about your concerns so that we can continue to work effectively with you and your family to provide the highest quality of care possible.

Client Rights & Grievance Procedure Acknowledgement

By signing this form, I acknowledge receipt of the Client Rights Notice and the Grievance Procedure.

_____	_____	_____
Name of Parent/Guardian	Signature of Parent/Guardian	Date
_____		
Name of Client		

Notice of Privacy Practices & Acknowledgement

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions, please contact our Privacy Officer, whose name and number are at the bottom of this notice.

Who will follow this notice?

The Children's Home of Cincinnati provides health care to our clients in partnership with physicians and other professionals and organizations. The information privacy practices in this notice will be followed by:

- Any health care, mental health or social service professional that provides services to you at any of our locations.
- All departments and units of our organization, including: the Mental Health Services Department and Every Child Succeeds Program and all locations of these departments and programs.
- All employed associates, staff or volunteers of the Mental Health Services Department and the Every Child Succeeds Program.
- Any business associate or partner of The Children's Home of Cincinnati with whom we share health information.

Our pledge to you.

We understand that health care information about you is personal. We are committed to protecting health care information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care that we maintain, whether created by facility staff or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office. We are required by law to:

- Keep health care information about you private.
- Give you this notice of our legal duties and privacy practices with respect to health care information about you.
- Follow the terms of the notice that is currently in effect.

Changes to this Notice.

We may change our policies at any time. Changes will apply to health care information we already hold, as well as new information after the change occurs. Before we make a significant change in our policies, we will change our notice and post the new notice in waiting areas, exam rooms, and on our Web site at www.thechildrenshomecinti.org

You can receive a copy of the current notice at any time. The effective date is listed just below the title. You will be offered a copy of the current notice each time you register at our facility for treatment. You will also be asked to acknowledge in writing your receipt of this notice.

How we may use and disclose health care information about you.

- We may use and disclose health care information about you for treatment (such as sending health care information about you to a specialist as part of a referral); to obtain payment for treatment (such as sending billing information to your insurance company or Medicaid); and to support our health care operations (such as comparing client data to improve treatment methods.)
- We may use or disclose health care information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out health care information about you without prior authorization for public health purposes, abuse or neglect reporting, health oversight audits or inspections, research studies, funeral arrangements and organ donation, workers' compensation purposes, and emergencies. We also disclose health care information when required by law, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders.
- We also may contact you for appointment reminders, or to tell you about or recommend possible treatment options, alternatives, health-related benefits or services that may be of interest to you, or to support fundraising efforts (provided that we give you the opportunity to opt out of future fundraising efforts).
- If admitted as a client, unless you tell us otherwise, we will list in the client directory your name, service area and program enrollment, your general condition and your religious affiliation, and will release all but your religious affiliation to anyone who asks about you by name. Your religious affiliation may be disclosed only to a clergy member, and even if they do not ask for you by name.
- We may disclose health care information about you to a friend or family member who is involved in your medical care, or to disaster relief authorities so that your family can be notified of your location and condition.

Other uses of health care information.

In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing health care information about you. For example, although we are unlikely to ever do so, if we share your health care information for marketing purposes or if your health care information includes psychotherapy notes, we must get your written authorization before using or disclosing such information. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Your rights regarding health care information about you.

- In most cases, you have the right to look at or get a copy of health care information that we use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

- If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information was not created by us; if it is not part of the health care information maintained by us; or if we determine that record is accurate. You may appeal, in writing, a decision by us not to amend a record.

- You have the right to a list of those instances where we have disclosed health care information about you, other than for treatment, payment, health care operations or where you specifically authorized a disclosure, when you submit a written request. The request must state the time period desired for the accounting, which must be less than a 6-year period and starting after April 14, 2003. Your may receive the list in paper or electronic form. The first disclosure list request in a 12-month period is free; other requests will be charged according to our cost of producing the list. We will inform you of the cost before you incur any costs.

- If this notice was sent to you electronically, you have the right to a paper copy of this notice.

- You have the right to request that health care information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.

- You may request, in writing, that we not use or disclose health care information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. In most cases, we will consider your request but we are not legally required to accept it. We will inform you of our decision on your request. The one exception is that, under new rules, if you pay entirely for a service 'out of pocket,' we must honor your request to not share information about that service with your insurance company or other payer.

- You now have a right to be notified following a breach of your unsecured heath information.

All written requests or appeals should be submitted to our Privacy Officer (contact information listed below).

Complaints

- If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Privacy Officer (contact information listed below).

- Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Officer can provide you the address.

- Under no circumstance will you be penalized or retaliated against for filing a complaint.

Privacy Officer

The Children's Home of Cincinnati

5050 Madison Road, Cincinnati Ohio 45227

(513) 272-2800

By signing this form, I acknowledge receipt of the Notice of Privacy Practices.

_____	_____	_____
Name of Parent/Guardian	Signature of Parent/Guardian	Date
_____		
Name of Client		

Education Center
Cincinnati Public Schools
P.O. Box 5381
Cincinnati, Ohio 45201-5381
Phone: (513) 363-0075
Fax: (513) 363-0055
www.cps-k12.org

Parent/Guardian Consent Form
Student Computerized Records

The Cincinnati Public Schools partners with a number of organizations to assist with addressing student needs. These organizations include:

• The Children's Home of Cincinnati • Mt. Washington Elementary After School • Midway After School	• Silverton Paideia After School

The partners offer an array of services related to the following areas: tutoring, mentoring, health, and after school services. Services are organized and expedited through coordinators who are assigned to individual schools.

The coordinators or partner organizations may request access to the student computerized records system, including IEP data, to view personally identifiable student data. This data may also be shared with staff and volunteers working with the partner organization. This would enable the coordinators and partner organizations to identify and assign appropriate services to students. If granted access, the coordinator or partner organizations must maintain the confidentiality of student information, and not re-disclose the information to persons not identified in this consent. The coordinator and partner organizations are only permitted to access student records in their own program and to the extent necessary to perform his/her duties. In addition, the coordinator or partner organizations may share information about his/her program with school district staff and other partners listed above, in order to better serve students.

Confidential information may only be shared to the extent that the information is relevant to the student's educational progress, safety, or well being. Student information may be disclosed in a grave medical emergency which necessitates facilitation of medical care.

A parent/guardian authorization is required to allow the coordinator and partner organizations access to your child's data. Please indicate your consent below.

I have read the above and consent to all partners listed above serving <u>Cincinnati Public Schools</u> to release, obtain, and exchange my child's information from school district staff and partners listed above.

_____ _____
Parent/Guardian Name (print) **Student Name (print)**

_____ _____
Parent/Guardian Signature **Date** **Phone Number**

_____
Parent/Guardian Email Address

For Office Use Only

Student ID #: _____

Mt. Washington Elementary

"The Little Clinic"

7580 Beechmont Ave

Cincinnati, Ohio 45255

Midway Elementary School

"The Little Clinic"

6165 Glenway Ave

Cincinnati, Ohio 45211

Silverton Paideia Elementary

"The Little Clinic"

4613 Marburg Ave

Cincinnati, Ohio 45209