



115 South Frederick Avenue  
Gaithersburg, Maryland 20877  
Tel: (301) 990-2441 xt.330

## Contrato Y solicitud de Padres y Proveedor

Bienvenidos al programa de cuidado de niños después de la escuela. Estamos muy emocionados de recibir a sus hijos este año escolar 2023-2024. Por favor completar el registro and regresar lo con los otros documentos adjuntos en este paquete.

Fecha de registro \_\_\_\_\_ Fecha de comienzo \_\_\_\_\_

Nombre de el niño/niña \_\_\_\_\_ Edad \_\_\_\_\_ Sexo \_\_\_\_\_

Fecha de cumpleaños \_\_\_\_\_

Nombre de el niño/niña \_\_\_\_\_ Edad \_\_\_\_\_ Sexo \_\_\_\_\_

Fecha de cumpleaños \_\_\_\_\_ Dirección \_\_\_\_\_

Ciudad/código postal \_\_\_\_\_

Nombre de madre/padre 1 \_\_\_\_\_

Numero De teléfono móvil \_\_\_\_\_ Trabajo \_\_\_\_\_

Correo electrónico \_\_\_\_\_

Dirección \_\_\_\_\_ ciudad/código postal \_\_\_\_\_

Nombre de madre/padre 1 \_\_\_\_\_

Numero De teléfono móvil \_\_\_\_\_ Trabajo \_\_\_\_\_

Correo electrónico \_\_\_\_\_

Dirección \_\_\_\_\_ ciudad/código postal \_\_\_\_\_

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después de las 6pm \$5 por minute cuando recogen su hijo tarde. El pago debe ser en efectivo

Firma/Nombre: \_\_\_\_\_ Fecha: \_\_\_\_\_



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Por favor decide, Tiempo complete o parte de tiempo

1. Cobro de registraci3n: \$35.00 por familia
2. Se aceptan pagos en efectivo or cheque, endors3ndolo: **SMS - Aftercare**
3. **El programa abre de Lunes a Viernes – Aftercare (3:00pm a 6:00pm\*)** Opci3n a elegir abajo:
  - a. **Tiempo Completo: 3 d3as o mas a la semana**
    - i. \$100.00 a la semana, por chico
  - b. **Parte de el tiempo: 2 d3as a la semana (no incluye las horas de medio d3a, esas horas se pagan separado)**
    - i. \$55.00 Por chico
  - c. **1 d3a de servicio: \$10.00 la hora, por chico**
4. **\*Pago tarde:** *despu3s de las 6pm \$5 el minuto. Efectiv3 solamente, pagar el mismo d3a*
5. Escoge tu opci3n a pagar:
  - Opci3n 1:** Yo/nosotros, preferimos pagar semanal (pagos son el Lunes de la semana).
  - Opci3n 2:** Yo/nosotros, preferimos pagar mensual (pagos son el primer Lunes de Mes).

# MontgomeryCountyMD.GOV

Montgomery County Government

## The Working Parents Assistance Program

Montgomery County's Working Parents Assistance (WPA) Program is a County-sponsored program that is committed to helping eligible county residents pay for child care. While parents are at work or school, they can feel confident that their children are in a safe and caring environment.

**Service(s):** Household Related Public Assistance Programs  
Parents  
Low Income

**Target Population:**

**Information Number:** 240-777-1177

**Location(s):**

***DHHS Offices***

7300 Calhoun Pl., Rockville, MD 20855

## How to Apply

Click on the link below to complete an application for the Working Parents Assistance Program (WPA) online. Once the form is displayed, click next to each section and complete each section. Sign the application, print and submit the WPA application by email to [wpa@montgomerycountymd.gov](mailto:wpa@montgomerycountymd.gov).

English:

[https://www.montgomerycountymd.gov/HHS-Program/Resources/Files/CYF%20Docs/WPA%20English%20%209\\_2018.pdf](https://www.montgomerycountymd.gov/HHS-Program/Resources/Files/CYF%20Docs/WPA%20English%20%209_2018.pdf)

Spanish:

[https://www.montgomerycountymd.gov/HHS-Program/Resources/Files/CYF%20Docs/WPA%20Spanish%209\\_18.pdf](https://www.montgomerycountymd.gov/HHS-Program/Resources/Files/CYF%20Docs/WPA%20Spanish%209_18.pdf)

## Documents to Bring

- **Proof of earned income** such as pay stubs or letter from the employer.
- **Proof of all unearned income** such as SSDI, veterans' benefits, or unemployment.
- **Proof of enrollment in** vocational training or undergraduate school attendance.
- **Proof of identity** such as driver's license, Maryland ID, or passport for parent(s) or guardians.
- **Proof of address** such as apartment lease, driver's license, or utility bills with current address.

- **Birth certificates**--copy of birth certificate for all children in the household, or any other government issued identification.
- **Proof of child support**--single parents must provide child support documentation or voluntary child support statements.
- **Copy of previous year's federal tax return.**

## Eligibility Requirements

You may qualify for the Working Parents Assistance Program if you:

You may qualify for the Working Parents Assistance Program if you:

- Are a Montgomery County resident
- Meet income guidelines
- Are a parent of guardian of a child from birth to 13 years old (up to 19 years old if the child has a disability and needs care)
- Are pursuing child support through the court, voluntarily or claim a good cause
- Must be employed 25 hours or more per week or enrolled in a fulltime undergraduate/vocational program or combination of both

### Note:

- Immigration status is not a requirement for parents or children to participate in the WPA program.
- Your selected child care provider must be licensed by the State of Maryland.

Families who meet the following incoming categories may be eligible for the Working Parents Assistance Program (WPA):

<b>Family Size</b>	<b>Minimum Annual Income*</b>	<b>Maximum Annual Income**</b>
Family of 2	\$61,223	\$ 82,395
Family of 3	\$75,628	\$103,635
Family of 4	\$90,034	\$124,875
Family of 5	\$104,439	\$146,115
Family of 6	\$118,844	\$167,355
Family of 7	\$121,545	\$188,595
Family of 8	\$124,246	\$209,835
Family of 9	\$126,947	\$231,075
Family of 10	\$129,648	\$252,315
Family of 11	\$132,349	\$273,555
Family of 12	\$135,050	\$294,795
Updated 7/12/22		

CACFP Enrollment: Yes:  No:

Meals your child will receive while in care:

BK  LN  SU  AM Snk  PM Snk  Evng Snk

**EMERGENCY FORM**

**INSTRUCTIONS TO PARENTS:**

- (1) Complete all items on this side of the form. Sign and date where indicated. Please mark "N/A" if an item is not applicable.
- (2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
 Last First

Enrollment Date \_\_\_\_\_ Hours & Days of Expected Attendance \_\_\_\_\_

Child's Home Address \_\_\_\_\_  
 Street/Apt. # City State Zip Code

Parent/Guardian Name(s)	Relationship	Contact Information		
		Email:	C:	W:
			H:	Employer:
		Email:	C:	W:
			H:	Employer:

Name of Person Authorized to Pick up Child (daily) \_\_\_\_\_  
 Last First Relationship to Child

Address \_\_\_\_\_  
 Street/Apt. # City State Zip Code

Any Changes/Additional Information \_\_\_\_\_

**ANNUAL UPDATES**

\_\_\_\_\_  
 (Initials/Date) (Initials/Date) (Initials/Date) (Initials/Date)

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name \_\_\_\_\_ Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
 Last First

Address \_\_\_\_\_  
 Street/Apt. # City State Zip Code

2. Name \_\_\_\_\_ Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
 Last First

Address \_\_\_\_\_  
 Street/Apt. # City State Zip Code

3. Name \_\_\_\_\_ Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
 Last First

Address \_\_\_\_\_  
 Street/Apt. # City State Zip Code

Child's Physician or Source of Health Care \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_  
 Street/Apt. # City State Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**INSTRUCTIONS TO PARENT/GUARDIAN:**

- (1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
- (2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medical Condition(s): \_\_\_\_\_

Medications currently being taken by your child: \_\_\_\_\_

Date of your child's last tetanus shot: \_\_\_\_\_

Allergies/Reactions: \_\_\_\_\_

**EMERGENCY MEDICAL INSTRUCTIONS:**

(1) Signs/symptoms to look for: \_\_\_\_\_

(2) If signs/symptoms appear, do this: \_\_\_\_\_

(3) To prevent incidents: \_\_\_\_\_

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OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

**Note to Health Practitioner:**

If you have reviewed the above information, please complete the following:

\_\_\_\_\_  
Name of Health Practitioner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Health Practitioner

(\_\_\_\_\_) \_\_\_\_\_  
Telephone Number



**AFTER CARE PERMISSION SLIP**

Name of Parent: \_\_\_\_\_

Mobile Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Name of Child(children): \_\_\_\_\_

I give permission for the following:

Mrs. Ruiz, Ms Ro, Mrs. Gomes

Location: City of Gaithersburg Park/ Train Museum

Date: 2022-2023 Calendar year

Time: Weekly from 3pm-4:45pm; half days 12:30pm-2:30pm

**Health Declaration**

In the event of an emergency it is vital we have contact details for your son/daughter.

**Any known allergies/disabilities:** \_\_\_\_\_

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**Emergency Numbers**

Name: \_\_\_\_\_ Number: \_\_\_\_\_

Name: \_\_\_\_\_ Number: \_\_\_\_\_

I agree that the information stated above is correct and that the information may be distributed to leaders it may concern.

Signed (parent/ guardian): \_\_\_\_\_





## Passive Technology Viewing Release Form

I, the parent/guardian of \_\_\_\_\_, understand that as part of my child's enrollment in the Pre-Kindergarten program at Saint Martin of Tours Catholic School, my daughter/son may participate in screen time activities during school hours. I understand that regulations set forth by the state of Maryland, referenced below, restrict the amount of Screen Time Activities per week for children and provide for exceptions in certain instances.

### C. Screen Time Activities.

(1) Definitions. In this section, the following terms have the meanings indicated:

(a) "Interactive technology" means educational and age-appropriate technology, including programs, applications (apps), noncommercial television programming, videos, streaming media, and ebooks that is designed to:

- (i) Facilitate active and creative use of technology; and
- (ii) Encourage social engagement with other children and adults.

(b) "Passive technology" means noninteractive television, videos, and streaming media

(2) Limited use of appropriate interactive technology may support, but may not replace, creative play, physical activity, hands-on exploration, outdoor experiences, social interactions, and other developmentally appropriate learning activities for children 2 years old or older.

(3) Viewing Restrictions. Except as set forth in §C(4) of this regulation, a child in attendance who is:

- (a) Younger than 2 years old may not be permitted to view any passive technology; and
- (b) 2 years old or older may not be permitted to view more than 30 minutes of age-appropriate, educational passive technology per week.

(4) Exceptions.

(a) An occasional exception to the weekly passive technology viewing limit set forth in §C(3) of this regulation may be made for a special event or project, including a holiday or birthday celebration, or for educational content that is related to the child care home's curriculum.

- COMAR 13A.16.09

I, \_\_\_\_\_, have read the above regulations regarding Screen Time Activities and agree that my child, named above, can participate.

\_\_\_\_\_  
Parent/ Guardian Signature

\_\_\_\_\_  
Date