



Dear Family:

Thank you for your interest in the Elaine Clark Center. I have enclosed our Waitlist application.

Once your Waitlist application has been received, your child or children will be placed on the list. There is nothing to pay until conformation of a spot is available.

If you currently have evaluations of your child such as physical therapy, occupational therapy, and speech therapy evaluations, please include this with your application. In addition, any other pertinent medical or developmental information on your child such as doctor's reports or current IFSP or IEP would be helpful in ensuring we will be able to provide the best care for your child.

If you have any questions or need additional information, you can contact me at 770-458-3251 or fax 770-458-7977.

Sincerely,

Leslie White  
Social Services Coordinator

Enclosures



\*\*\*\*\*IMPORTANT INFORMATION\*\*\*\*\*

CENTER HOURS:

7:30 a.m. to 6:00 p.m. Parents picking their children up after 6:00 p.m. will be charged a late fee of \$1.00 per minute.)

ATTENDANCE

Each child is allowed sixty excused absences per school year. Our school year begins July 1 and ends June 30. For those children beginning after July 1, the number of allotted absences will be prorated for the number of months the child will attend school during the year. Children must arrive by 10:00 a.m. unless arrangements have been made with the teacher or social worker.

FEES

Tuition rates are as follows:

Infant	\$215.00
Toddler	\$205.00
Two Year Old	\$190.00
Three and Four Year Olds	\$180.00
School Age	\$165.00
After School (ages 3-7)*	\$ 95.00
Before and After School	\$115.00
Daily Rate for Children in Before & After School Care**	\$ 20.00
PLAY Program	
Tues. & Thurs.	\$ 50.00
Multi-Child Discount	\$ 25.00 (per family)

Tuition fees must be paid by noon on Wednesday of each week or a \$15.00 late fee will be charged.

A nonrefundable annual registration fee of \$50.00 is due upon application and annually thereafter.

\* Transportation is not provided. Hours are 1:30-6:00.

\*\*Daily rates are for children enrolled in the before and/or after school program.

# THE ELAINE CLARK CENTER

## IDENTIFYING INFORMATION

CHILD'S NAME \_\_\_\_\_ D.O.B. \_\_\_\_\_

COUNTY of RESIDENCE \_\_\_\_\_ HOME PHONE # \_\_\_\_\_

BIRTH PLACE  
Hospital \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

SERVICE COORDINATOR  
Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Requested Beginning Date \_\_\_\_\_

\_\_\_\_\_ Full Time Program \_\_\_\_\_ Mother's Morning Out

---

ATTACH PHOTO

MEDICAID # \_\_\_\_\_

HEALTH INSURANCE CARRIER \_\_\_\_\_

POLICY NUMBER \_\_\_\_\_

IS THIS CLIENT COVERED UNDER THIS  
POLICY? YES \_\_\_\_\_ NO \_\_\_\_\_

---

LEGAL GUARDIAN \_\_\_\_\_

RELATIONSHIP TO CHILD \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ COUNTY \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

CELL PHONE \_\_\_\_\_ E-MAIL \_\_\_\_\_

---

For center use only: Date Received \_\_\_\_\_

Registration Received \_\_\_\_\_ Yes \_\_\_\_\_ No

## CHILD INFORMATION SHEET

CHILD'S FULL NAME \_\_\_\_\_ D.O.B. \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ COUNTY \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_ RACE \_\_\_\_\_ SEX \_\_\_\_\_

---

### IF THIS CHILD IS CURRENTLY IN FOSTER CARE PLEASE COMPLETE THIS PORTION

FOSTER PARENT(S) NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ COUNTY \_\_\_\_\_ ZIP \_\_\_\_\_

WORK NUMBER \_\_\_\_\_ HOME NUMBER \_\_\_\_\_

CASEWORKER'S NAME \_\_\_\_\_

COUNTY \_\_\_\_\_ AGENCY \_\_\_\_\_

---

### EMERGENCY CONTACTS (Other than Parents)

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ COUNTY \_\_\_\_\_ ZIP \_\_\_\_\_

WORK NUMBER \_\_\_\_\_ HOME NUMBER \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ COUNTY \_\_\_\_\_ ZIP \_\_\_\_\_

WORK NUMBER \_\_\_\_\_ HOME NUMBER \_\_\_\_\_

**PARENT INFORMATION**

MOTHER (FULLNAME) \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

OCCUPATION \_\_\_\_\_

EMPLOYER \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ MARITAL STATUS M \_\_\_ S \_\_\_ D \_\_\_ W \_\_\_

FATHER (FULL NAME) \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

OCCUPATION \_\_\_\_\_

EMPLOYER \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ MARITAL STATUS M \_\_\_ S \_\_\_ D \_\_\_ W \_\_\_

**BROTHERS AND SISTERS**

NAME	D.O.B.	LIVING IN THE HOME

**OTHERS LIVING IN THE HOME**

NAME	D.O.B.	RELATIONSHIP

## HOW CAN WE HELP?

CHILD'S NAME \_\_\_\_\_ DATE \_\_\_\_\_

All children enrolled at The Elaine Clark Center have their own strengths and needs. Please use this form to tell us how we can be most helpful to your family. We know that your needs will change from time to time and that this will just be a beginning point to help us plan together with you. Answer only those questions that you think will help us know how we can be most helpful to you and your family.

1. What pleases you most about your child?
  
2. What worries you most about your child?
  
3. What kind of help or information would you like to have from The Elaine Clark Center?
  
4. Are there things that you feel are going well for your child and your family right now?
  
5. What would you like to see your child be able to do in the next several months?
  
6. Please tell us other ways we may be able to help.
  
7. Tell us about your child when he/she first came home from the hospital.
  
8. Tell us about your child's development now.
  
9. Does your child:  
 sleep well  
 sleep restlessly  
 hardly sleep  
Does your child nap?  yes  no
  
10. Does your child eat well?  yes  no

Does your child have difficulty swallowing? \_\_\_\_\_ yes \_\_\_\_\_ no

11. Does your child use a cup? \_\_\_\_\_ yes \_\_\_\_\_ no

Does your child use a spoon? \_\_\_\_\_ yes \_\_\_\_\_ no

Are there any foods that your child especially likes?

Are there any foods that your child dislikes?

12. How does your child usually let you know what he/she needs?

13. Are there any special things that you have noticed about your child's hearing?

14. Are there any special things that you have noticed about your child's vision?

15. How does your child respond to strangers?

16. How does your child respond to a sitter?

17. Does your child like to be held? \_\_\_\_\_ yes \_\_\_\_\_ no

18. Does your child like to be read to? \_\_\_\_\_ yes \_\_\_\_\_ no

19. Does your child like to be with other children? \_\_\_\_\_ yes \_\_\_\_\_ no

20. Is your child presently receiving:

Physical Therapy \_\_\_\_\_

Where \_\_\_\_\_

Occupational Therapy \_\_\_\_\_

Where \_\_\_\_\_

Speech Therapy \_\_\_\_\_

Where \_\_\_\_\_