



# APPLICATION FOR ENROLLMENT



|   |                                       |   |   |                                       |                       |
|---|---------------------------------------|---|---|---------------------------------------|-----------------------|
| Child's Name:   |                                       | <input type="checkbox"/> Male           | <input type="checkbox"/> Female             | Age:                                  |                       |
| Date of Birth (or due date):  |                                       |   |   |                                       |                       |
| Parent(s)/Legal Guardian:   |                                       |   |   |                                       |                       |
| Address:  |                                       |   |   | ( )                                   |                       |
| Street  |                                       | City                                    |   | Zip                                   |                       |
|   |                                       |   |   | Phone                                 |                       |
|   |                                       |   |   |                                       |                       |
| Parent/Guardian 1   | <input type="checkbox"/> SUNY Student | <input type="checkbox"/> State Employee | <input type="checkbox"/> Community Resident | <input type="checkbox"/> SCC Employee | Union Representation: |
| Parent/Guardian 2   | <input type="checkbox"/> SUNY Student | <input type="checkbox"/> State Employee | <input type="checkbox"/> Community Resident | <input type="checkbox"/> SCC Employee | Union Representation: |
|   |                                       |   |   |                                       |                       |
| <b>Hours of care required</b> : Please give times (we are open 7:00am - 5:30pm M-F)   |                                       |   |   |                                       |                       |
|   | Monday                                | Tuesday                                 | Wednesday                                   | Thursday                              | Friday                |
| Arrive at:  |                                       |   |   |                                       |                       |
| Depart at:  |                                       |   |   |                                       |                       |
| Indicate date you wish your child to begin:   |                                       |   |   |                                       |                       |
|   |                                       |   |   |                                       |                       |
| <b>If employed, Parent/Guardian's place of employment:</b>  |                                       |   |   |                                       |                       |
| Name:   |                                       |   | Name:                                       |                                       |                       |
| Place:  |                                       |   | Place:                                      |                                       |                       |
| Tel. #:   |                                       |   | Tel. #:                                     |                                       |                       |
| Days/Hours  |                                       |   | Days/Hours                                  |                                       |                       |
| Soc. Sec #  |                                       |   | Soc. Sec #                                  |                                       |                       |
|   |                                       |   |   |                                       |                       |
| <b>Does your child have special needs?:</b>   |                                       |   |   |                                       |                       |
| <p>Fees are determined by a sliding fee scale based on gross household income. Verification of income will be required upon enrollment.<br/> <b>A \$20 non-refundable fee must accompany this application.</b> Make your check payable to: Bugbee Children's Center.<br/>         Send the check with this application to:<br/>         Bugbee Children's Center • Bugbee Hall • State Street • Oneonta, NY • 13820</p> |                                       |   |   |                                       |                       |
| Parent/Guardian Signature:  |                                       |   |   |                                       |                       |

The following information is requested by the Federal Government in order to monitor compliance with Federal Laws prohibiting discrimination against applicants seeking to participate in this program. You are not required to furnish this information, but are encouraged to do so. This information will not be used in evaluating your application or to discriminate against you in any way. However, if you choose not to furnish it, we are required to note the race/national origin of individual applicants on the basis of visual observation or surname.

Enrollee information:

|                   |  |  |
|-------------------|--|--|
| <b>Ethnicity:</b> | <input type="checkbox"/> Hispanic or Latino            | <input type="checkbox"/> Not Hispanic or Latino                    |
| <b>Race:</b>      | <input type="checkbox"/> White                         | <input type="checkbox"/> Black or African American                 |
| <b>Gender:</b>    | <input type="checkbox"/> Male                          | <input type="checkbox"/> Female                                    |
|                   | <input type="checkbox"/> American Indian/Alaska Native | <input type="checkbox"/> Asian                                     |
|                   |  | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |

This is an Equal Opportunity Program. Discrimination is prohibited by Federal law. Complaints of discrimination may be filed with the USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington DC 20250-9410 or call (202)720-5964

|                 |              |                  |
|-----------------|--------------|------------------|
| For office use: | Received by: | Date Received:   |
|                 | Amount Paid: | Check/Receipt #: |

Questions? Please call (607) 436-2484