

Booker T. Washington's Success Academy After School Program Application

Success Academy
After School Program Application

Semester 1: August 27, 2018 - December 21, 2018

Semester 2: January 7, 2019 - June 4, 2019

In addition to completing this application please provide

A copy of participant most recent report card

A copy of the front and back of your child's medical insurance card

A copy of the participant reading level



After School Program 2018-2019

Progress Reports: Every 4th Tuesday of the month

Public School/Program Closed Days

September-3 rd Labor Day (CLOSED)	February 5 th - Lunar New Year's Observed (Closed)
October-8 th Columbus/Indigenous People Day (Closed)	February 18 th Presidents Day (Closed)
November-12 th Veterans' Day (Closed)	March 25 th -29 th Spring Break
November-19-23 rd Thanksgiving Recess (Closed)	March-29 th - Cesar Chavez Day (Closed)
December-24 nd -January 4 th - Winter Recess (Closed)	May-27 th Memorial Day Observance (Closed)
January-21 st M.L. King Jr. Day (Closed)	

Parent's Meetings (3rd Tuesdays)

September-18 th (Tuesday)	Parents Open house 5:30-6:30pm (Conference Room)
November-20 th (Tuesday)	Parent Meeting 5:30-6:30pm (Conference Room)
January-22 nd (Tuesday)	Parent Meeting 5:30-6:30 (Conference Room)
March-19 th (Tuesday)	Parent Meeting 5:30-6:30pm (Conference Room)
May-21 th (Tuesday)	Parent Meetings 5:30-6:30pm (Conference Room)

Events

September-21 nd - Show and Tell (4:30-5:30pm)	February 22 nd - Black & White Ball (Time:TBA)
October 26 th - Lights On After School (4:00-5:30pm)	April 5 th - Booker T. Tribute - B-day Recognition
October 31 st - Halloween Event 4:30-6:00pm	April 26 th - Spelling Bee (4:00-6:00pm)
November 16 th -Thanksgiving Event 5:30-7pm	May 17 th - Literacy Night (4:30-6:00pm)
December 21 st - Christmas Event (5:00-6:30pm)	May 19 th - Western Addition Spelling Bee (4:30-6:00)
February 25 th - Black History Event/Showcase (5-6:30pm)	May-31 st - End of the year Celebration

Fridays

1st Friday of the month is Library Day
 2nd Friday of the month is STEAM
 3rd Friday of the month is Game Day/Family Engagement
 4th Friday of the month is field trip/outing

Field Trips/Family Activities (3rd Fridays)

October 19 th - Family Engagement (5:30-7pm)	March 15 th - Family Engagement (5:30-7pm)
October 20 th *Goblin Jamboree Haunts the Museum	April-19 th Family Engagement (5:30-7pm)
November 16 th Family Engagement (5:30-7pm)	May-17 th Family Engagement (5:30-7:30pm)
January 18 th Family Engagement (5:30-7pm)	
March- 1 st - 3 rd Snow Trip (Overnight)	

Spring Day Camp : March 25th -29th Spring Camp 7:30-5:30pm
 \$100 for ASP Participants \$250 - Non After School Program Participants

Summer Day Camp (Sliding Scale): June 11th - August 10th - 9 weeks

Registration Fee/Transportation Payments

K-5th - Enrollment Fee/Semester-\$200.00/Semester, \$400/Year
 6th - 8th - Enrollment Fee/Semester-\$125.00/Semester, \$250/year
 Transportation Fee Separate: \$45/Month

Booker T. After School Success Academy

Program Application

___ K-5 AS Program ___ 6th-8th AS Program ___ 9th - 12th AS Program

Student Contact Information

Student Name:	Date of Birth
Grade in September:	Age:
Gender: (Check) Male Female	
Home Address:	Zip Code
Student Cell phone number:	Student Home phone:
Racial/Ethnic Identity of students (please list all that apply):	
Please specify which days your child will attend the program: <i>(3 days required)</i>	
<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday (optional)	
How will the student leave the program daily: (Check all that apply)	
<input type="checkbox"/> Car <input type="checkbox"/> Walking <input type="checkbox"/> bus <input type="checkbox"/> (other)	
List of people who can pick up student (All adults must present proper identification):	
1.	2.
3.	4.

School Information

Name of School:	Grade:
Homeroom Teacher:	School Counselor:
List of student classes (you can attach sheet if needed)	

What are your academic challenges/least favorite subject?
If any (Please be as specific as possible)

What is your academic strength/favorite subject?
If any (Please be as specific as a possible)

Do you child have an IEP? ___ yes ___ no. If so, please provide us a copy of the IEP.
Do you receive any academic support at school? ___ yes ___ no
If yes, please specify: _____

For High School Students: Are your enrolled in any honor classes? ___ yes ___ no
Last school year, did you make the Honor Roll? ___ yes ___ no, when? fall, spring, both

Booker T. After School Success Academy
Program Application

Household Information

Name of Parent/Guardian # 1	
Home number:	work number:
Cell number:	Preferred phone #:
Home Address:	Zip Code
Work Address:	Zip Code
Email Address:	

Name of Parent/Guardian # 2	
Home number:	work number:
Cell number:	Preferred phone #:
Home Address:	Zip Code
Work Address:	Zip Code
Email Address:	

Medical and Emergency Information

Child's Name:	
Parent(s) Name:	work/cell number:
work/cell number:	

Emergency Contacts: (Please note all adults must present valid ID upon pick up)

Name	Phone Number
Name	Phone Number
Name	Phone Number

If another adult attempts to pick up your child, we will not release your child until we receive either verbal or written communication from you.

Authorization for Release of Confidential Information

Booker T. Washington Community Service Center

Participant Name: _____ Date of Birth: _____

Our agency is supported by a grant from the San Francisco Department of Children, Youth, and Their Families (DCYF). As a condition of the funding we receive, we are required to report information about the services we provide and the children, youth, and families that we serve to DCYF. DCYF works in close partnership with the San Francisco Unified School District (SFUSD). The data that we report to DCYF is also shared with SFUSD.

DCYF and SFUSD rely on the data that we provide to understand the populations that are served by DCYF-funded programs and to ensure that San Francisco's most vulnerable children, youth, and families have access to services. The data is also used by DCYF to monitor grant funds and to evaluate program activities and impacts.

By signing this form, you authorize our agency to share information about your child's participation in our program (or your participation, if you are 18 years of age or older) with authorized staff at DCYF and SFUSD for the purposes described above. The information that we report to DCYF includes:

- Personal information, such as name, date of birth, and address;
- Demographic information, such as race/ethnicity and gender identity;
- Education information, such as school name and grade level;
- Participation in activities and services, such as attendance dates and hours attended; and
- Anonymous and voluntary youth experience surveys.

DCYF and SFUSD will not publicly report any information that we provide in a way that may be used to identify your child (or you, if you are 18 years of age or older).

Restrictions: All information that we provide that is related to an SFUSD student is protected by federal and state laws that govern the use, disclosure, and re-disclosure of student education records. Parties other than DCYF and SFUSD will not have access to any personally identifiable information that we report, except to the extent that the parties have obtained prior written authorization from you or have followed SFUSD policies and procedures to obtain access to such information.

Expiration: This authorization expires on June 30, 2023.

Your Rights: You may refuse to sign this form. You may cancel it at any time by informing our agency in writing. If you cancel your permission allowing us to release information to DCYF and SFUSD, it will go into effect immediately, unless the information has already been released. You have a right to receive a copy of this form.

Your Name: _____

Relationship to Participant: Parent Legal Guardian Participant 18 Years of Age or Older

Signature: _____ Date: _____



Mayor's Office of Housing and Community Development
City & County of San Francisco

2018-2019 Family Income Verification Form

The Mayor's Office of Housing and Community Development (MOHCD) collects client information to meet specific federal, state, and local reporting requirements and to improve program quality and service delivery. MOHCD protects all clients' personally identifiable information from unauthorized disclosure.

Agency Instructions

1. Use the Family Income Verification Form Instructions to help with form completion.
2. Please **complete** and **review** this form **with client**.
3. This form must be kept on **file for five years**.
4. **All items must be completed** unless noted as optional.

Client Information

Client Name/Unique Identifier _____ Date of Birth ____ / ____ / ____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ e-mail: _____
(Optional) (Optional)

Which best describes your ethnicity? (Check one. Please also select from the "race" options below)

- Hispanic/Latino Not Hispanic/Latino

Which best describes your race? (Check one)

- | | |
|---|---|
| <input type="checkbox"/> American Indian/Alaskan Native | <input type="checkbox"/> American Indian/Alaskan Native <i>and</i> Black/African American |
| <input type="checkbox"/> Asian | <input type="checkbox"/> American Indian/Alaskan Native <i>and</i> White |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Asian <i>and</i> White |
| <input type="checkbox"/> Native Hawaiian/Other Pacific Islander | <input type="checkbox"/> Black/African American <i>and</i> White |
| <input type="checkbox"/> White | <input type="checkbox"/> Other/Multiracial |

Cultural Affiliation or Nationality (optional): _____

What is your gender? (Check one that that best describes your current gender identity)

- | | |
|--|---|
| <input type="checkbox"/> Female | <input type="checkbox"/> Trans Female |
| <input type="checkbox"/> Male | <input type="checkbox"/> Trans Male |
| <input type="checkbox"/> Genderqueer/Gender Non-binary | <input type="checkbox"/> Not Listed. Please Specify _____ |

How do you describe your sexual orientation or sexual identity? (Check one)

- | | |
|--|--|
| <input type="checkbox"/> Bisexual | <input type="checkbox"/> Straight/Heterosexual |
| <input type="checkbox"/> Gay /Lesbian/Same-Gender Loving | <input type="checkbox"/> Not listed. Please specify: _____ |
| <input type="checkbox"/> Questioning /Unsure | <input type="checkbox"/> Decline to answer |

Which best describes your family? (Check one)

Family includes, but is not limited to the following—regardless of actual or perceived sexual orientation, gender identity, or marital status—a single person or a group of persons residing together.

- Single Headed Family Dual Headed Family

Number of persons living in your family (including yourself): _____

Total estimated income for next 12 months for all adult members: \$ _____

Current Income Information (Number of persons in "family" above must match this section)

(Circle correct income level. If number of family members is greater than eight persons, refer to instruction sheet)

Family of:	1 person	2 persons	3 persons	4 persons	5 persons	6 persons	7 persons	8 persons
Extremely Low Income	\$0 – 30,800	\$0 - 35,200	\$0 – 39,600	\$0 – 44,000	\$0 – 47,550	\$0 – 51,050	\$0 – 54,600	\$0 – 58,100
Low Income	\$30,801- 51,350	\$35,201- 58,650	\$39,601- 66,000	\$44,001- 73,300	\$47,551- 79,200	\$51,051- 85,050	\$54,601- 90,900	\$58,101- 96,800
Moderate Income	\$51,351- 82,200	\$58,651- 93,950	\$66,001- 105,700	\$73,301- 117,400	\$79,201- 126,800	\$85,051- 136,200	\$90,901- 145,600	\$96,801- 155,000
Above Moderate Income	\$82,201 or greater	\$93,951 or greater	\$105,701 or greater	\$117,401 or greater	\$126,801 or greater	\$136,201 or greater	\$145,601 or greater	\$155,001 or greater

Income Certification

Interviewer: Check the income level of the client and indicate below the source of information used to verify this information.

*Please see instruction sheet to help with completion (**current-within 2 months).*

- CalWorks Food Stamps Medi-CAL Tax Return (most recent) Unemployment (check stub)
- SSI** Payroll Stub** Other (i.e. public housing/foster care) **
- Self-certified. Please explain _____

I hereby certify that, to the best of my knowledge, the above statements are true and correct. I understand this information is subject to verification only by authorized HUD (U.S. Department of Housing & Urban Development)/CDBG officials (for federally funded grants).

CLIENT

INTERVIEWER

Client Printed Name

Interviewer Printed Name

Parent/Client Signature

Interviewer Signature

Date

Date

NOTES:



ACTIVITIES CONSENT AND RELEASE OF LIABILITY: YOUTH

Please complete and sign this Activities Consent and Release of Liability. The consents and releases in this form will govern your child's activities held at or sponsored by the Booker T. Washington CSC (BTWCSC), both now and in the future. This form includes a release. Please read the release carefully. By signing this form, you are giving up important legal rights, including your and your child's right to sue.

Participant _____ Date of Birth _____

Parent/Legal Guardian's Name _____

In consideration of my Child's participation in the Activities, I hereby, on behalf of myself and my Child, acknowledge and agree with the BTWCSC as follows:

1. Voluntary Participation and Permission.

I acknowledge that now and in the future, I am voluntarily choosing to have my child named above (my "Child") participate in activities organized, sponsored or otherwise administered by the BTWCSC, which may include activities such as the use of the BTWCSC fitness studio, gymnasium, and other recreation classes, day trips, sports leagues and clinics, afterschool programs and camps (collectively, and including transportation to and from such activities, the "Activities"). I agree to abide by BTWCSC policies and procedures in connection with the Activities. I give permission for my Child to participate in the Activities.

2. Assumption of Risk & Release of Liability.

I am aware that many risks are inherent in the Activities, and that some of these risks cannot be eliminated, altered or controlled. I understand that these risks can cause injury, illness or death to my Child or damage to my Child's belongings. I knowingly and freely assume all risks and hazards in the Activities, both known and Released Parties"), or by defects in equipment or instruction. I assume full responsibility for my Child's participation in the Activities. I acknowledge and agree to be solely responsible for my Child's safe and responsible entry upon and use of all BTWCSC facilities and equipment, whether or not supervised by a BTWCSC representative. RELEASE. In consideration for my Child being permitted to participate in the Activities, I agree not to make a claim against or sue the Released Parties, and I release and hold harmless the Released Parties from and against all demands, actions or claims of liability arising out of the negligence or any other act or omission by the Released Parties that causes my Child's illness, injury, death and/or damage to my Child's belongings as a result of participation in the Activities.

3. Health Insurance/Physician Consultation.

I understand that it is my responsibility to carry accident or medical coverage for my Child in connection with the Activities. I also acknowledge that prior to engaging in the Activities, I have been advised to consult with and receive the approval of a physician.

4. Consent for Emergency Medical Treatment.

In the event of an emergency or non-emergency situation requiring medical or dental treatment, I hereby grant permission for any and all medical and dental care to be administered to my Child, until such time as I or the designated emergency contact can be contacted. This permission includes, but is not limited to, the administered of first aid, the use of an ambulance, and the administration of anesthesia and/or surgery under the recommendation of qualified medical personnel. I authorize BTWCSC staff members to transport my Child in a personal vehicle in case of a medical emergency. I further authorize the BTWCSCS to release my Child's personal information necessary for medical or insurance purposes. I agree to release the BTWCSC and the Released Parties from any and all liability for medical or dental aid rendered, and I understand that I am responsible for all medical or dental expenses incurred for such aid.

5. Photo/Video/Testimonial Release.

I hereby grant the Booker T. Washington CSC (BTWCSC) the unrestricted right to take, use, distribute and publish photographs, video or audio recordings, or quotations from interviews of me and/or my child(ren) and family, or in which I/we may be included, for editorial, fundraising and/or promotional and advertising purposes and in any manner and medium, including but not limited to use in social media and distribution to media or funding organizations; and to alter and composite the same without restriction and without my/our inspection or approval. I understand that the photographer has permission to use images for personal promotion and owns the copyright. I understand that if I wish to revoke permission I must do so in writing. I also agree that there is to be no financial compensation for the use or publication of my/our interviews, photographs or video or audio recordings, and I/we hereby release the BTWCSC and persons functioning under its authority from all claims and liability relating to the same.

I affirm that I am a legal competent adult, and if signing on behalf of a minor affirm that I am the minor's parent or legal guardian and have a right to contract for the minor. I have read this release before signing below and fully understand its contents and meaning. I acknowledge that I have carefully read this Activities Consent and Release of Liability, that I fully understand its contents, and that I am signing it voluntarily. This Activities Consent and Release of Liability shall remain in full force and effect until the BTWCSC receives a signed revocation from me.



BOOKER T WASHINGTON
COMMUNITY SERVICE CENTER

ACTIVITIES CONSENT AND RELEASE OF LIABILITY: YOUTH

This Activities Consent and Release of Liability form must be signed by the Participant's parent or legal guardian.

Parent or Legal Guardian's Signature _____ Date _____

Emergency Contact Name (1) _____ Home/Cell _____ Work _____

Emergency Contact Name (1) _____ Home/Cell _____ Work _____

Current Medical Conditions and Allergies _____

Current Medications _____

Participant's Doctor _____ Phone _____

Health Insurance Company _____ Policy No. _____

Complete and Return By _____



DCYF Photography Release Form

Participant Name: _____ Date of Birth: _____

You or your child participates in a youth program funded by the San Francisco Department of Children, Youth, and Their Families (DCYF). DCYF staff or contractors may on occasion visit this program to take photographs for public information projects.

The public information projects aim to educate civic leaders and the general public about programs and services available for San Francisco children, youth and families. Example projects include DCYF publications and exhibits, as well as the DCYF website (<http://www.dcyf.org>).

By signing this form, you authorize DCYF staff and contractors to take photographs of program activities that may include images of you or your child and to use these photographs for the public information projects described above.

Your Name: _____

Relationship to Participant: Parent Legal Guardian Participant 18 Years of Age or Older

Signature: _____ Date: _____



Authorization for Payment by Bank or Credit Card Draft

Monthly payments will be automatically deducted from your designated bank account or credit card number secured on file on the fifteenth (15th) of each month, per payment options agreed to in the registration form. Monthly tuition payments are the same amount regardless of the number of classes/weeks in the month, or vacation/holiday closures. There are no refunds or adjustments for missed days or vacation breaks.

Select one of the following tuition payment options:

c Pay by Bank Draft *(must attach a voided check)*

Name on Account _____

Bank Name _____

Bank Routing Number _____

Checking Account Number _____

c Pay by Credit Card on File

Name on Credit Card _____

Credit Card Billing Address _____

Credit Card Number _____ CVV _____

Credit Card Expiration Date _____

I hereby authorize my financial institution/credit card company to charge my account on the fifteenth (15th) of each month and pay to the Booker T. Washington Community Service Center the monthly installment for the program in which I am enrolling my child pursuant to the monthly installment schedule agreed to in the payment options of the registration form.

I understand that the authority to charge my account at the bank shall be the same as if I had signed a check payable to the BTW-ASP. This authority shall remain in full force and effect until tuition and fees are paid in full. A record of charges will appear on my monthly bank statement. That statement will serve as a receipt. The BTWCSC is authorized to make adjustments or entries to correct errors. **There will be an additional \$40 charge to my bank draft if payment is refused for insufficient funds.** If there is any change to my account, I agree to notify the BTWCSC immediately and allow 30 days to process the bank draft. I understand that I may need to provide alternative payment until the new bank draft takes effect.

Signed _____ Date _____

Name (please print) _____