Goddard Riverside

INVESTING IN PEOPLE, STRENGTHENING COMMUNITY

August 2023

Dear Parents/Guardians:

We are pleased to announce registration for the After School Program 2023-2024 for children in grades K-6. The After School Program will operate from September 18th, 2023 through June 14th, 2024, Monday — Friday, 2:45pm to 5:45pm on regular school days.

Registration is open and will continue until all spaces are filled. You can pick up an application at the Lincoln Square Neighborhood Center (250 West 65th Street). Forms will also be available for download from our website http://www.goddard.org

If you have questions, please email lsncyouth@goddard.org or lsncafterschool@gmail.com
$50 Registration Fee due with application submission. **ALL PAYMENTS ARE NON- REFUNDABLE.**

- Amsterdam Houses Residents: $100/Month, $900/ Year **(Must show proof of residence)**
- Returning After School Participants: $170/ Month, $1,530/ Year
- New Participants: $245/ Month, $2,205/ Year

There is a 10% discount (with a 20% max) for the following:

- Each sibling registered
- Payment for two or more months made in advance (this discount is included in yearly amount above)

We will have escort service from the following schools at no additional cost:

- **PS 199, PS 452 & Special Music School**

The following will be needed to complete registration:

- $50 Non- Refundable Registration Fee/ Family
- Registration Contract
- Income Eligibility Form (CACFP Snack Form)
- Health Examination Form (current within 1 year with Immunization Records)
- Copy of most recent report card or school progress report
- Proof of Income (2022 W-2 or 2 recent pay stubs or Budget Letter)
- Attendance at Mandatory Parents' Orientation in September - Date TBA

Tutoring is available at the Star Learning Center for second grade and up, contact Monica Enciso for information at 212-799- 2369, menciso@goddard.org. We also provide full day services from 8:00am to 6:00pm during the public school mid-winter and spring recesses. Additional fees apply for these services.

Contact our **Beacon** office at (212) 866-0009 for registration and information about the After School Program for Elementary, Middle School youth in grades 6-8 and High School and Adult programming.

Please feel free to call us with any questions.
Sincerely Yours,

Tamika Gayle
Director, Youth Services
Lincoln Square Neighborhood Center

Goddard Riverside

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Agosto de 2023

Estimados Padres / Guardianes:

Nos complace anunciar la inscripción para el programa después de la escuela 2023-2024 para niños de 5 a 12 años. El Programa Después de la Escuela funcionará desde el 18 de septiembre de 2023 hasta el 14 de junio de 2024, lunes - viernes, de 2:45pm a 5:45 pm los días escolares regulares.

La inscripción esta abierta hasta que los cupos se agoten. Aplicaciones estaran disponibles en Lincoln Sqaure Neighborhood Center (250 West Calle 65th) Los formularios también estarán disponibles para descargar desde nuestro sitio web http://www.goddard.org

Si tiene preguntas, comuníquese con lsncyouth@goddard.org o lsncafterschool@gmail.com

Precios: El pago $50 para regitrar su hijo/a cuando entreges la aplicacion. No hay devoluciones de dinero.

Para los que son:

- Residentes de Amsterdam Houses: $100/ mensual,$900/ annual (**Debe mostrar comprobante de domicilio**)
- Participantes que regresan al program despues de la escuela: $170/ mensual,$1,530/ anual
- Participantes nuevos: $245/ mensual, $2,205/ anual

Hay un descuento del 10% (con un máximo del 20%) para lo siguiente:

- Cada hermano registrado
- Pagos completos de dos meses o mas (se incluye tambien para un pago anual)

Buscaremos participantes de las siguientes escuelas a ningun costo a usted:
PS 199, **PS 452** y **Special Music School**

Lo siguiente será necesario para completar el registro:

- Pago del primer mes de programa. (descuento de 10% si paga por dos meses)
- Contrato de registro
- Formulario de Elegibilidad de Ingreso Formulario de Solicitud de Tutoría (Grados 2-5)
- Formulario de examen de salud (actual dentro de un año)
- Copia de la boleta de calificaciones más reciente o informe de progreso de la escuela
- Prueba de Ingresos (2022 W-2 o 2 recibos de pago recientes o Carta de Presupuesto.
- Asistencia obligatoria a la orientación de los padres en septiembre - Fecha no decidida

La tutoría está disponible en el Centro de Aprendizaje de Estrellas para el segundo grado y en adelante. Comunicarse con Monica Enciso para obtener información al 212-799-2369, menciso@goddard.org. También ofrecemos servicios de día completo de 8:00 am a 6:00 pm durante cierre de la escuela pública a mediados de invierno y recesos de primavera. Se aplican cargos adicionales por estos servicios.

** Póngase en contacto con nuestra oficina de Beacon al (212) 866-0009 para registrarse e información sobre el programa después de la escuela para jóvenes de la escuela intermedia en los grados 6-8 y sobre la programación de la escuela secundaria y adultos.
Por favor, no dude en llamarnos con cualquier pregunta.

Tamika Gayle
Directora, Servicios para adoloescentes

El Centro de Vecindad de Lincoln Square

Goddard Riverside

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AFTER SCHOOL PROGRAM/LSNC REGISTRATION CONTRACT 2023-2024/ PROGRAMMA DEPUES DE LA ESCUELA CONTRATO DE REGISTRO 2023-2024

Completes

Registration Date/ Fecha de hoy		Group/Activity/ Member ID	
PARTICIPANT INFORMATION/INFORMACIÓN DEL PARTICIPANTE			
Last Name/ Apellido		First Name, Middle/ Nombre, Inicial	
Home Address/ Dirección		Apt/ Apto	
City/Cuidad	Manhattan Queens Bronx Brooklyn Staten Island		
State/Estao	☐ NY ☐ NJ ☐ ____	Zip Code/ Codigo Postal	
Home Telephone/ Teléfono de su casa			
Housing/ Vivienda	Rental/Alquiler Other/Otro	NYCHA Housing/Projectos NYCHA [2 Family Owned/ Propiedad Familar	
Age/Edad		Gender/Sexo	DM No Response
Date of Birth/ Fecha de Nacimiento (mm/dd/yyyy)		Primary Language Spoken/Lenguaje Principal	
Current Grade/ Grado		School/ Escuela	
Class/Room. Clase/habitación		Teacher's Names/ Nombre de la Maestra(o)	
School Type/ Tipo de Escuela	[ ] Public/Publica. [ ] Parochial/Parroquial	[ ] Charter/Carta [ ] Home School	[ ]Private/Privada [ ]Other/Otro
Does Child have an IEP		If Yes, date of recent evaluation	
Does Child have a 504 Plan?		If Yes, date of recent plan	

Lincoln Square Neighborhood Center
250 West 65th, NY, NY 10023
(212) 874-0860
Fax (212) 799-6574 lsncafterschool@gmail

Race/ Ethnicity/ Raza/Etnicidad (Select All That Applies)	☐ Hispanic or Latino ☐ Non-Hispanic or Non- Latino ☐ American Indian/lndio Americano ☐ Asian/Asiático ☐ Black/African-American/Afroamericano ☐ Other/ Multi-Race/Otro/Multi-Raza a pacific Islander/lsleño Pacificas White/Blano

Any Medical Conditions/Allergies/ Alguna condición medica/Alergias	Y/N	If yes explain/ Sies si porfavor de explicar	

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Youth's Last Name/ Apellido		Youth's First Name/ Nombre	
PARENT/GUARDIAN INFORMATION/INFORMACION DEL PADRE/GUARDIAN			
Primary Parent/Guardian			
Last Name/ Apellido		First Name/ Nombre	
Relationship/Relación			
Home Telephone/Teléfono de la casa			
Cell/Other Telephone/Teléfono del cellular			
Business Telephone/Teléfono del trabajo			
Email Address/Coreo Electronico			
Primary Language Spoken/ Lenguaje Primario			
Are you a registered voter? /¿Usted esta registrado para votar?			
Are you or any member of your household (0-64 years of age) covered by Medicaid, Child Health Plus, Family Health Plus or private medical insurance? / ¿Usted o algún miembro de su familia (de 0-64 años) tienen el seguro de Medicaid, Child Health Plus, Family Health Plus o seguro médico privado?			
Additional Contact			
Last Name/ Apellido		First Name/ Nombre	
Relationship/Relación			
Home Telephone/Teléfono de la casa			
Cell/Other Telephone/Teléfono del cellular			
Business Telephone/Teléfono del trabajo			
Email Address/Coreo Electronic			

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Youth's Last Name/ Apellido		Youth's First Name/ Nombre	

EMERGENCY CONTACTS & DISMISSAL AUTHORIZATION / CONTACTOS DE EMERGENCIA Y AUTORIZACIÓN PARA RECOGER A LOS NIÑOS

Please provide us with a list of additional names and telephone numbers of alternate persons whom we may contact in case of emergency. Designate any of these people as authorize to pick up your child by checking the box beside their name. I will notify Goddard Riverside Community Center if there are any changes in the persons named in emergency contacts and dismissal authorizations Parent/Guardian is automatically included as an authorized person. Authorized escorts under 14 old years of age will be allowed at the Program's discretion. / Por favor provenos con una lista de nombres y telefonos de personas que podemos llamar en caso de emergencia y que pueden recoger a su hijo(a) del programa. Yo notificaré a Goddard Riverside Community Center si hay cambios en los nombres de las personas que estan en los contactos de emergencia y autorización de partida. Padres/Guardianes están automáticamente incluidos como personas autorizadas. Escortas autorizadas menos de 14 años de edad serán permitidos a la discreción del programa.

Last Name/Appellido	First Name/Nombre	Telephone/Telefono	Relationship/ Relación	Pick Up/ Recojer

I give permission for my child to walk home alone. / Yo autorizo a que mi hijo/a camine solo a su casa.	Yes / No
Child may not be picked up by: /EI nino no puede ser recogido por:	

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Youth's Last Name/ Apellido		Youth's First Name/ Nombre	

PARENT/GUARDIAN CERTIFICATION & AGREEMENT/ CERTIFICACIÓN Y ACUERDO DEL PADRE O GUARDIÁN

Last Name/Apellido	First Name/Nombre	Relationship/ Relación

As a condition of registration of my child in the PROGRAM of GODDARD RIVERSIDE COMMUNITY CENTER (CENTER), I agree to the following:/Como condición del registro de mi hijo(a) en el PROGRAMA en GODDARD RIVERSIDE COMMUNITY CENTER, yo convengo 10 siguiente:

All of the given information on registration contract is correct. I will follow program rules and regulations including making adequate arrangements to have young children picked up at dismissal time. I will, to the best of my ability, support my child's participation and development and will communicate with the CENTER to accomplish these goals. /Toda la información en el contrato de registración esta corecta. Yo entiendo las reglas y polizas y voy a hacer 10 mejor possible para recoger a mi hijo(a) a tiempo al la hora de partida del programa. Yo voy hacer 10 mejor possible para apoyar a mi hijo(a) durante su participación en le programa.

PARTICIPATION/ PARTICIPACIÓN: I agree to participate in Parent/Family Events including attending meetings, volunteering or contributing to special events. /Yo participaré en las Actividades de los Padres 10 cual incluye reuniones, ser voluntario o contribuir a evento especiales.

TRIP PERMISSION/ PERMISO PARA PASEOS: I hereby give my child permission to participate in all program activities, field trips, sports, arts, recreation and events with the CENTER during regular program hours, within the New York City/Tri State area. /Yo doy permiso para que mi hijo(a) valla a los paseos con el programa durante las horas regulares.

WAIVER/ RENUNCIA: I hereby authorize Goddard Riverside Community Center and DYCD or any of its designees to photograph and record, both digital and analog, my child for any and all purposes in connection with Goddard Riverside Community Center and DYCD. I agree to hold Goddard Riverside Community Center and DYCD harmless from any liability arising out of photographs, digital images, videos and recordings and waive any compensation for pictures, printed works or audio/visual products of or by my child. /Yo autorizó a Goddard Riverside Community Center y DYCD que retraté o grabe a mi hijo(a) para todo los propositos en conexión a Goddard Riverside Community Center. Estoy de aguerdo con mantener a Goddard Riverside Community Center y DYCD libre de toda responsabilidad que pueda surgir de las fotografias, imagenes, videos y grabaciones de mi hijo(a).

MEDICAL AUTHORIZATION/ AUTORIZACIÓN MEDICA: In the event of an emergency, and after every attempt has been made to contact me, I hereby give permission for the agency, Goddard Riverside Community Center, to get medical treatment for my child. I further authorize the doctor or the hospital to which my child may be brought and whomever they may designate as their assistant, to perform any emergency procedure or operation on my child during their attendance in the Goddard Riverside Community Center program. /En el evento de una emergencia, y depués de que todos los medios de comunicarse conmigo sean agotados, yo le doy permiso a la agencia de Goddard Riverside Community Center de obtener atención medica para mi hijo(a). Además autorizo al medico y al hospital que pueden hacer qualquier procedimiento de emergencia o cirugia durante su asistencia en Goddard Riverside Community Center.

_____ _____/_____/_____

Parent/Guardian Signature/ Firma del Padre/Guardián Date/Fecha

CACFP
Child and Adult Care Food Program
New York State Department of Health

INCOME

Youth's Last Name/ Apellido		Youth's First Name/ Nombre	
PROGRAM FEES/HONORARIOS DEL PROGRAMA			
Gross Annual Income		Number of People In Household	
FEE			
Resident of Amsterdam Houses/NYCHA		$100/ Month	
Returning After School Participants		$170/ Month	
New Participants		$245/ Month	

Program Discounts. Check all that apply. Each entry is a 10% discount from total fee with a maximum of 20% discount.

☐ Two (or more) Month's of Tuition Paid In Full* payments are due on the first business day of every month.

☐ Enrolling one or more siblings in LSNC After School Program

Financial Assistant Organizations

HRA/ACS Household

All payments are due on the first business day of the month!

*

I agree to pay the program fees to Goddard Riverside Community Center for the registration of my child in the After School Program. A non-refundable deposit of $50 is required at time of registration. Please select recommended payment options. Other arrangements can be discussed. I understand if I do not make the appropriate payments, my child may be dropped from the program.

Once tuition is paid, there are NO REFUNDS!

Yo me comprometo a pagar el costos a Goddard Riverside Community Center por el ingreso de mi hijo/ a en el programa después de la escuela. La tasa de inscripcion no reembolsable de $50.00 un depósito se requiere en el momento de registrar al niño/a en el programa. Por favor seleccione de las recomendaciones para pagar a continuación. Otros arreglos se pueden discutir. Yo entiendo que si no hago los pagos a los que me comprometí, mi hijo/a podría ser removido del programa. / Once tuition is paid, there are NO REFUNDS!

_____ _____/_____/_____

Parent/Guardian Signature/ Firma del Padre/Guardián Date/Fecha

INCOME ELIGIBILITY FORM
for Child Care Centers

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME: Goddard Riverside Community Center

_____

Print the name of the child(ren) enrolled in this child care center:

1. _____ 2. _____ 3. _____

DIRECTIONS:

Complete SECTION A if anyone in your household:

1. Receives Food Stamps
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR) OR
4. If any of the children enrolled in this child care center are foster children

Complete SECTION B if no one in your household receives Food Stamps, TANF, FDPIR or if none of the children enrolled in the child care center is a foster child.

<table>
<tr><td>Section A</td><td colspan="2">Section B</td></tr>
<tr><td rowspan="2">Food Stamp Case Number

TANF Number

FDPIR Number

Names of

Foster Children

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true. I understand that the center will get Federal funds based on the information I give.

Signature:

Date:</td><td colspan="2">List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received last month in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, child support, foster child's personal income and any other sources of income.</td></tr>
<tr><td>Name of Household Members

1.

2.

3.

4.

5.

6.</td><td>Month Gross Income</td></tr>
<tr><td>FOR SPONSOR USE ONLY

Sponsor Agreement Number

Total Household Members
(Including foster children, if applicable)

Total Income S

Free Reduced Paid

Date Determined

Signature of
Center Staff</td><td colspan="2">An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true and that all income is reported. I understand that the center will get Federal funds based on the information I give.

Signature:

Print Name:

XXX-XX- Date:</td></tr>
</table>

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Confirmation of Meals Served

Child's Name: _____ **Age**: _____

Is enrolled at:

_____

(**Site Name**)

_____

(**Site Address**)

Start date: _____

(**Month/Day/Year**)

Directions: Parent/Guardian, write your initials on the line to indicate permission.

As the parent/legal guardian of the child _____, I give permission by initialing below for the following:

_____ My Child will attend the program: [ ] Monday. [ ] Tuesday. [ ] Wednesday. [ ] Thursday. [ ] Friday

From _____ to _____

(**Drop off time**) (**Pick up time**)

_____ My child will receive [ ] Breakfast [ ] Lunch [ ] Snack [ ] Supper five (5) days per week (Monday to Fridays) in accordance with CACFP nutrition guidelines, Head Start/Daycare Food Menus and the food and allergy restrictions set by parent/guardian.

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS) ☐☐☐☐☐☐☐☐☐

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name	First Name	Middle Name	Sex ☐ Female ☐ Male	Date of Birth (Month/Day/Year) __/__/__

Child's Address

Hispanic/Latino? ☐ Yes ☐ No

Race (Check ALL that apply) ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other ____

City/Borough	State	Zip Code	School/Center/Camp Name	District Number	Phone Numbers
			Goddard Riverside Comm Ctr		Home ____

Health Insurance (including Medicaid)? ☐ Yes ☐ No

☐ Parent/Guardian ☐ Foster Parent — Last Name — First Name — Email

Cell ____ Work ____

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history (age 0-6 yrs)

☐ Uncomplicated ☐ Premature: ____ weeks gestation

☐ Complicated by ____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs (list) ____

☐ Foods (list) ____

☐ Other (list) ____

Attach MAF if in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma (check severity and attach MAF): ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status: ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes (attach MAF)
☐ Orthopedic injury/disability

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis (latent infection or disease)
☐ Hospitalization
☐ Surgery
☐ Other (specify) ____

Explain all checked items above. ☐ *Addendum attached.*

Medications (attach MAF if in-school medication needed) ☐ None ☐ Yes (list below)

PHYSICAL EXAM Date of Exam: __/__/__

Height	____ cm	___ %ile
Weight	____ kg	___ %ile
BMI	____ kg/m²	___ %ile
Head Circumference (age ≤2 yrs)	____ cm	___ %ile
Blood Pressure (age ≥3 yrs)	____ / ____	

General Appearance:

☐ Physical Exam WNL

Nl Abnl	Nl Abnl	Nl Abnl	Nl Abnl	Nl Abnl
☐ ☐ Psychosocial Development	☐ ☐ HEENT	☐ ☐ Lymph nodes	☐ ☐ Abdomen	☐ ☐ Skin
☐ ☐ Language	☐ ☐ Dental	☐ ☐ Lungs	☐ ☐ Genitourinary	☐ ☐ Neurological
☐ ☐ Behavioral	☐ ☐ Neck	☐ ☐ Cardiovascular	☐ ☐ Extremities	☐ ☐ Back/spine

Describe abnormalities:

DEVELOPMENTAL (age 0-6 yrs)

Validated Screening Tool Used? ☐ Yes ☐ No — Date Screened __/__/__

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern:

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< 1 year ☐ Breastfed ☐ Formula ☐ Both

≥ 1 year ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes (list below)

SCREENING TESTS	Date Done	Results
Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk)	__/__/__	____ µg/dL
	__/__/__	____ µg/dL
Lead Risk Assessment (annually, age 6 mo-6 yrs)	__/__/__	☐ At risk (do BLL) ☐ Not at risk
— Child Care Only —		
Hemoglobin or Hematocrit	__/__/__	____ g/dL ____ %

Hearing	Date Done	Results
< 4 years: gross hearing	__/__/__	☐ Nl ☐ Abnl ☐ Referred
OAE	__/__/__	☐ Nl ☐ Abnl ☐ Referred
≥ 4 yrs: pure tone audiometry	__/__/__	☐ Nl ☐ Abnl ☐ Referred
Vision	**Date Done**	**Results**
<3 years: Vision appears:	__/__/__	☐ Nl ☐ Abnl
Acuity (required for new entrants and children age 3-7 years)	__/__/__	Right __/__ Left __/__ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No
Dental		
Visible Tooth Decay		☐ Yes ☐ No
Urgent need for dental referral (pain, swelling, infection)		☐ Yes ☐ No
Dental Visit within the past 12 months		☐ Yes ☐ No

CIR Number ☐☐☐☐☐☐☐☐☐☐

Physician Confirmed History of Varicella Infection ☐

IMMUNIZATIONS – DATES

DTaP/DTP	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_
Td	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_	
Polio	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_	
Hep B	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_	
Hib	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_	
PCV	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_	
Influenza	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_	
HPV	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_	

Tdap	_/_/_	_/_/_	_/_/_
MMR	_/_/_	_/_/_	_/_/_
Varicella	_/_/_	_/_/_	_/_/_
Mening ACWY	_/_/_	_/_/_	_/_/_
Hep A	_/_/_	_/_/_	_/_/_
Rotavirus	_/_/_	_/_/_	_/_/_
Mening B	_/_/_	_/_/_	_/_/_
Other ____	_/_/_	_/_/_	_/_/_

Report only positive immunity:

IgG Titers	Date
Hepatitis B	_/_/_
Measles	_/_/_
Mumps	_/_/_
Rubella	_/_/_
Varicella	_/_/_
Polio 1	_/_/_
Polio 2	_/_/_
Polio 3	_/_/_

ASSESSMENT ☐ Well Child (Z00.129) ☐ Diagnoses/Problems (list) — **ICD-10 Code**

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions (specify) ____

Follow-up Needed ☐ No ☐ Yes, for ____ Appt. date: __/__/__

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other ____

Health Care Practitioner Signature	Date Form Completed __/__/__	DOHMH ONLY — PRACTITIONER I.D. ☐☐☐☐☐☐
Health Care Practitioner Name and Degree (print)	Practitioner License No. and State	TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s) Comments:
Facility Name	National Provider Identifier (NPI)	
Address / City / State / Zip		Date Reviewed: __/__/__ — I.D. NUMBER ☐☐☐☐☐☐☐ REVIEWER:
Telephone / Fax	Email	FORM ID# ☐☐☐☐☐☐☐☐☐☐

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Credit Card Payment Authorization Form

Sign and complete this form to authorize Goddard Riverside Community Center @ LSNC to make recurring charges to your credit card listed below. By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for recurring transactions.

Please complete the information below:

I _____ authorize Goddard Riverside Community Center @ Lincoln
(full name)
Square Neighborhood Center to charge my credit card account indicated below for _____
(amount)
on _____of every month.
(date)

This payment is for _____.
(description of goods/services)

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV _____

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for one time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Goddard Riverside

INVESTING IN PEOPLE, STRENGTHENING COMMUNITY

Credit Card Payment Authorization Form

Sign and complete this form to authorize Goddard Riverside Community Center @ LSNC to charge your credit card listed below. By signing this form you give us permission to debit your account for the amount indicated upon receipt of this form.

This is permission for a one-time transaction.

Please complete the information below:

I _____ authorize Goddard Riverside Community Center @ Lincoln
(full name)
Square Neighborhood Center to charge my credit card account indicated below for _____
(amount)
upon receipt of this form.

This payment is for _____.
(description of goods/services)

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV _____

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for one time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.