



Risen Christ
CHRISTIAN ACADEMY

Child Development Center Financial Agreement

Responsible Party's Name _____ Relationship _____

Responsible Party's Address _____

City _____ State _____ Zip code _____

Account Holder's Phone _____ Home or Cell

Payment Method: Debit Authorization Form:

I (we) hereby authorize Risen Christ Lutheran Church and School, hereinafter called "COMPANY", to initiate electronic debit entries to my (our) account indicated below and Sandhills Bank named below, hereinafter called "FINANCIAL INSTITUTION", to debit the same to such account for the purpose of School tuition , Child Care or other School expenses.

I (we) acknowledge that ACH transactions I (we) authorize must comply with all applicable laws, including U.S. law. In the event of an erroneous or duplicate entry, I hereby authorize COMPANY to credit my account indicated below to correct any error made. **Please Attach Copy of Voided Check to this form**

Financial Institution _____

Address _____

City, State, Zip _____

Routing Number: _____ Account Number: _____

Type of Account: Checking: _____ Savings: _____

Amount of debit \$ _____ Frequency (Weekly, Monthly, etc.): _____ Start Date (if recurring): _____ # Of Months _____

- *If the debit is recurring and the date of the debit falls on a non-banking day, the debit may post to your account on the next banking day and will not post to your account prior to the authorized date.*

Note: For varying amounts the company must send, based on the Nacha Operating Rules, written notification of the amount and the date on or after which the transfer will be debited at least ten calendar days in advance of the debit. If the date varies, the Rules state that the Originator must send the Receiver notification of new date at least seven calendar days in advance of the debit.)

This authorization is to remain in full force and effect until COMPANY has received written notification of termination in such time and manner as to afford Company a reasonable opportunity to act on it.

Signature

Date

Print Individual Name



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CHILD'S NAME:		ROOM	DATE OF BIRTH:
RESPONSIBLE PARTY'S NAME:		RELATIONSHIP:	
RESPONSIBLE PARTY'S ADDRESS (NOTE: IF DIFFERENT, PLEASE PRINT STUDENT'S ADDRESS ON REVERSE SIDE):			
CITY:		STATE:	ZIP:
HOME PHONE:	CELL PHONE:	WORK PHONE:	

Child Care Registration / Enrollment Fee per child \$150.00

Child Care Weekly Tuition Fee \$160.00

Late Pick up Charge per child per minute \$2.00

Weekly Payment Method:

Cash or Personal Check – I will pay by cash or personal check on or before Tuesday each week.

Credit or Debit (ACH) Card – I authorize the payment to be automatically billed to the following card on or before Tuesday of each week All credit card transactions are subject to a 3.5% fee. Please complete the attached payment method form.

The Risen Christ Christian Academy Board of Education reserves the right to change our fees at any time after providing thirty (30) days written notice It is the parents' responsibility to ensure payments are made on time. The School Finance Committee recognizes that special circumstances may require you to meet in person or by telephone concerning payments. Please contact the School's Administrative Office and they will schedule a meeting or phone conversation with the Finance Board to determine whether a payment solution can be resolved.

I (We) parents/guardians agree and understand that enrollment at Risen Christ Christian Academy Child Development Center is limited to a set number of children. Therefore, we understand that if payment is not made as agreed upon above, we forfeit our child's right to continue their care and education at RCCA CDC. We also understand that should we decide to withdraw our child from the Child Development Center, we are required to give (2) weeks advance notice and are financially responsible for these two (2) weeks.

I understand that late payments or returned payments will result in additional fees and that failure to adhere to this payment plan could result in the student's expulsion.

Parent/Guardian Signature

Parent/Guardian Signature

Date



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Payment Method:

Personal Check: I will pay by personal check on or before the Tuesday of each week. I understand that late payments or returned payments could result in additional fees and that failure to adhere to this payment plan could result in the student's expulsion. Returned checks are subject to a \$25.00 fee.

Parent/Guardian Signature

Parent/Guardian Signature

Date

Payment Method: Credit Card

STUDENT'S NAME:		GRADE:	DATE OF BIRTH
RESPONSIBLE PARTY'S NAME		RELATIONSHIP:	
RESPONSIBLE PARTY'S ADDRESS (NOTE: IF DIFFERENT, PLEASE PRINT STUDENT'S ADDRESS ON REVERSE SIDE):			
CITY:		STATE: ZIP:	
HOME PHONE:	CELL PHONE:	WORK PHONE:	

Credit I authorize the payment(s) to be automatically billed to the following card on or before Tuesday of each week All credit card transactions are subject to a 3.5% fee.

Credit Card Transactions – Please complete the following:

NAME ON ACCOUNT:		PHONE NUMBER:	
ACCOUNT NUMBER:		ZIP CODE:	
EXPIRATION DATE:		C V V #:	

Credit Card Authorized User Signature

Date

Child Name _____ Grade/Classroom _____