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**South Florida Autism Center, Inc.**

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**Before Care Program**

**2025-2026**

**Program Handbook & Application**

**South Florida Autism Center, Inc.**

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## Program Handbook

### **Mission Statement:**

SFAC intends to provide a safe, positive, and enriching experience for each child enrolled in our Before Care Program. Our program is designed to provide parents with flexibility regarding drop-off and pick-up times for their children. A student-to-teacher ratio of 3:1 is maintained at all times.

**Please note, this is not a “drop-in”**

### **Days & Times:**

The SFACS Before-School Care Program follows the Miami-Dade County Public Schools school-year calendar. Services are available on school days from 7:00 a.m. to 8:25 a.m. Before-School Services will not be offered the last week of School.

## **POLICIES & PROCEDURES:**

### **Attendance/Participation Policy:**

The SFACS Before Care Program is not a “drop-in” program. To maintain our 3:1 student-to-teacher ratio, we must have adequate notice of participation to ensure that we have enough staff. Therefore, Parents must make arrangements one month in advance for participation in Before-School Care. In extreme cases, you may attempt to schedule Before-Care one week before participation; however, we cannot guarantee enrollment.

### **Fee Schedule:**

#### **Before School Care Program: \$100 per month**

The Before-School Care fee is a flat fee that covers 7:00 to 8:25 a.m.

### **Discipline Policy:**

Behaviors will be addressed on a case-by-case basis, consistent with the methodologies utilized by SFACS during the regular school-day program.

### **Child Sign-In/Sign-Out Policy:**

Parents and Guardians who drop off children for the Before-School Care Program **must sign in each child daily.**

### **Withdrawal Policy:**

If you wish to withdraw your child from the Before-School Care Program, please see our School Administrator.

**Sick Policy:**

Parents/Guardians will be called to pick up children immediately if they appear sick. Signs of illness include, but are not limited to: green mucus, fever, pink eye, diarrhea and vomiting. It is the responsibility of the Parent/Guardian to pick up the child within a reasonable amount of time. We will make every effort to promptly notify parents in the event of a breakout of contagious illness.

Please note, if a child is sent home early from After-School Care, they are not to return to school/Summer Camp until being symptom-free for 24 hours.

**Returned Checks:**

Parents/Guardians will be responsible for restitution on returned checks, including fees and service charges. Only money orders will be accepted until returned checks and fees are paid in full.

**REGISTRATION INFORMATION:**

**Payment:**

Payment may be in the form of a check or money order, or you may make your payment by credit card in the main office. The completed Application and payment must be the week prior to commencement of participation.

**To register:**

Please complete the following Program Application & Agreement, and once completed, return to the School Administrator. We must receive payment and application one week prior to commencement of services so that we may make arrangements for staff.

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**South Florida Autism Charter Schools, Inc.  
Before- Care Program Application**

Child's Name: \_\_\_\_\_ Name called: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_ Present age: \_\_\_\_\_ Sex: \_\_\_\_\_

**Before-School Care: Time Child will be dropped off:** \_\_\_\_\_

Parent/Guardian's name: \_\_\_\_\_ Work hours: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Parent/Guardian's name: \_\_\_\_\_ Work hours: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Parent/Guardian's Email: \_\_\_\_\_

Parent/Guardian's Email: \_\_\_\_\_

Doctor's name & phone number: \_\_\_\_\_

Persons authorized to pick up the child:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Nearest relative/neighbor to contact in case emergency contacts & parents cannot be reached:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Allergies: \_\_\_\_\_

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**Before Care Agreement:**

This agreement is made on \_\_\_\_\_ (date) between South Florida Autism Center, IBefore-School Care Program, and the Parent/Guardian, \_\_\_\_\_, of child or children enrolled:

\_\_\_\_\_  
Name & Age

\_\_\_\_\_  
Name & Age

\_\_\_\_\_  
Name & Age

\_\_\_\_\_  
Name & Age

Who reside(s) at the following address:

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

1. I am enrolling my child \_\_\_\_\_ in Before School Care Program  
Drop-off time: \_\_\_\_\_
2. I agree to pay a flat rate of \$100 per month for Before-School Care. I agree to pay this amount one month in advance, for each month that I intend to utilize the service.
3. I agree that any unpaid balance will be automatically charged to my Credit Card on File by the 10<sup>th</sup> of the following month.
4. I have read the attached policies and procedures. Until these policies are changed, I accept them as they are and agree to abide by them.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

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**Credit Card Authorization Form:**

Visa: \_\_\_\_\_ MasterCard \_\_\_\_\_ Amex \_\_\_\_\_

Card Number: \_\_\_\_\_

Billing Zip Code: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Security Code: \_\_\_\_\_

Email Receipt to: \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

**To sign up for both Before Care & After Care services the registration fee is \$90.00 per family.**