





you agree to these terms

| Harrogate Skills 4 Living Centre | | | | | | | |
|---|---------------------------------|---|--|--|--|--|--|
| | Monthly Fees | Fees Per Session | | | | | |
| Half day: 10.00-12.15 or 12.45-3.00pm | £98.00 | £24.00 | | | | | |
| Full day: 10am - 3.00pm | £187.83 | £46.00 | | | | | |
| | | | | | | | |
| Complex disability carer supp *This is in recognition of the cost of a place | £10.00 Half day £15 Full Day | | | | | | |
| Gym and Fitness sessions 1 hour session at Brimham's Health and Fitn | £12.50 | | | | | | |
| 2021- 22 Monthly Fees Payable | | | | | | | |
| Own lunch must be provided. You may bring food to reheat in the microwave, at your own risk, provided you are competent to use a microwave unsupervised. | | Your signature is required, as acknowledgement that | | | | | |

| Name: | and conditions |
|---|---|
| Signature: | |
| Address: | I agree to set up payment by monthly Standing Order (please tick) |
| Email Address: | I have authorisation to enter into this financial agreement and (please tick one of the following): |
| Contact Tel. No. | I am the client |
| | I am the client's Carer/Parent |
| Please sign this form and return it to us: | I am the client's Care Manager |
| Harrogate Skills 4 Living Centre, 9 North Park Rd, Harrogate, HG1 5PD | I am the client's Key worker |
| We will issue you a copy for your records. | I am the client's Residential Care Provider |
| FOR OFFICE USE ONLY: | |
| Harrogate Skills 4 Living Centre | |







Date of Agreement _

Receiving Officer Signature: __





BOOKING FORM HS4LC COURSES

6th SEPTEMBER 2021 - 19th AUGUST 2022

| | Morning preferred course choice | Afternoon pre course choice | eferred | FOR OFFICE USE ONLY | | | |
|--|---------------------------------|--------------------------------|-------------------|------------------------|--|--|--|
| Monday | | | | | | | |
| Tuesday | | | | | | | |
| Wednesday | | | | | | | |
| Thursday | | | | | | | |
| Friday | | | | | | | |
| Additional Activities and Virtual Activities | | | | | | | |
| | | | | | | | |
| Full Name: | | | | | | | |
| Client Signature: | | | Date of Agreement | | | | |
| Care Provider: Date of Agreement Authorised Signatory (where responsible for finances) | | | | | | | |



