2022/2023 Y-Care Registration Form School Age Children K – 5th

Child's Name_____ Age_____ Grade_____

Parent/Guardian's Name (please print) _____

Address_____

Phone_____ Email_____

Child's DOB_____/_____/_____ Parent/Guardian DOB_____/_____/_____

Emergency Contact Name_____ Emergency Phone_____

YMCA Member: ❑ Yes ❑ No

Private Pay: _____ ELRC (Financial Assistance) Participant: _____ (Please provide approval letter)

Program Site: _____ Bloomsburg Memorial Elementary School (held at BAY)

_____ W.W. Evans Elementary School

Date Child will start Y Care: _____

Registration Fee: $25.00

Type of Care	Member Rate	Non-Member
5 Day		
___ Before & After	___$100	___$110
___ Before	___$70	___$80
___ After	___$70	___$80
3 Day		
___ Before & After	___$75	___$85
___ Before	___$50	___$60
___ After	___$50	___$60

I, _____ agree to pay the Bloomsburg YMCA $_____ per week for my child's Y care service.

Cancellation of care must be received in writing TWO WEEKS in advance of removal date.

You will be charged for the days that you attend. For example, if you attend 1 day then you will get charged for 3 days and if you attend 4 days then you will get charged for 5 days.

Parent/Guardian Signature: _____ Date: _____

Director Signature: _____ Date: _____

Method of Weekly Payment: ❑ Credit Card ❑ Bank Draft

Payment Method on file will be billed the Friday during the week of Y-Care scheduled.

Due at Registration:

Week 1 Fee $_____ Registration Fee $_____ Total $_____

Weekly Schedule

Please check the weeks and number of days your child will be attending care each week. If your child will be attending 3 days a week, please fill in the days they will attend. Any schedule changes MUST be made in writing or email to Serena Hampton one week prior to change.

	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival Time					
Departure Time					

Parents,

In order to resolve confusion at the front desk, we will need to be provided with a credit card or bank draft on file to be charged *weekly*. The charge will be scheduled in advance at registration and occur every Friday. This is needed to enroll your child/children into our Y-Care before and after school program. We apologize for any inconvenience this may cause, but it will help us to better serve you.

If you have any questions or concerns, please feel free to contact us.

Sincerely,
YMCA Administration
570-784-0188

Parent Signature: _____ Date: _____

Director Signature: _____ Date: _____

2022/2023 Y-Care
REGISTRATION AGREEMENT

I AGREE TO ADHERE TO THE BLOOMSBURG AREA YMCA Y-CARE REGISTRATION POLICIES OUTLINED IN THIS AGREEMENT AND GIVE MY CHILD PERMISSION TO PARTICIPATE FULLY IN THIS PROGRAM.
PLEASE READ EACH AGREEMENT, INITIAL TO THE RIGHT, AND SIGN FULL NAME.

1. **Registration must be completed before child may enter Y-Care and consists of the following: _____**
    a. A non-refundable registration fee of $25
    b. Signed agreement form by parent and/or guardian
    c. Emergency form for each child enrolled
    d. Health Assessments ~ must be current and are due within 30 days of the date on registration form
2. **I agree to pay the weekly fee as stated on the registration form. _____**
3. **I understand that I must have a valid credit card or bank draft information on file when my child(ren) register for Y-Care. _____**
4. **I understand that weekly fees will be CHARGED during THE Friday of that week of care. Any schedule changes must be made in writing to Serena Hampton one week prior to change. _____**
5. **I understand that childcare services WILL BE TERMINATED if my account reaches 3 weeks of non payments_____**
6. **In the event that payment is rejected or not processed, I give the Bloomsburg Area YMCA permission to collect payment in full via the credit card or bank draft on file. _____**
7. **No child may be dropped off before 6:30 AM. For your child's safety, if parent/child arrives before 6:30 AM, parent must wait for staff to arrive. Failure to wait could result in childcare services being terminated. A $5.00 per 5 min. fee will be charged if picked-up after 5:30 PM. If there is a problem with pick up, parent must call to notify Director of Youth Development & Family Engagement. A parent/gaurdian will be called after 15 minutes _____**
8. **An AUTHORIZED ADULT MUST SIGN child (ren) in upon arrival and sign child (ren) out upon departure DAILY. YMCA staff will only assume full responsibility for child (ren) when signed in for the program. YMCA STAFF WILL CHECK AUTHORIZED PICK UP PERSONS. PLEASE MAKE SURE PICK UP PERSONS HAVE PHOTO ID. _____**
9. **I understand that, whenever possible, I will be notified prior to medical treatment of my child. If notification is impossible, I understand that I am financially responsible for any medical or**

transportation expenses incurred on my child's behalf. _____

10. **I understand that it is a <u>STATE REQUIREMENT</u> that if my child requires medication that these <u>MEDICATIONS</u> must be in the <u>ORIGINAL BOTTLE</u> accompanied with doctor's instructions. _____**

11. **Any form of violence (whether physical or verbal), talking back or inappropriate language is not tolerated at any time. Should my child behave inappropriately I will be called into a conference and understand that my child may be liable for expulsion from the Y-Care Program without refund of fees. _____**

12. **In consideration of the Bloomsburg Area YMCA, I waive all claims of any lost, stolen, damaged valuables. Please do not send anything of value to the program with your child. _____**

    In consideration of the Bloomsburg Area YMCA program listed above, I waive all claims for myself and for the participants listed above, for any injuries or illness, which may result from participation, including any transportation provided by the YMCA, staff or agents. I further state that the above participant is in proper physical condition to participate in this program. In the event that there is a question regarding the physical condition of the participant, a physician will be consulted by parent/guardian to review the situation prior to any participation.

I agree to adhere to the Bloomsburg Area YMCA Registration agreement and policies for the

Y-Care Program as outlined and give my permission to participate fully in this program.

Parent/Guardian Signature_____ Date: _____

Director Signature: _____ Date: _____

CONDUCT POLICY

It is the intent of the Bloomsburg Area YMCA that each child enjoys the activities planned by understanding that he/she is responsible for his/her actions. With prior knowledge of our basic rules of safety and good conduct, each child is made aware of how to exercise self-discipline, and that the YMCA is here to help children and to know that we want him/her to succeed. As in any group activity, the inappropriate behavior of a few children can spoil the experience for the entire group. Therefore, the following conduct policies apply directly to each child and will be used in determining his/her eligibility to continue as a participant in the YMCA Y-Care Program. In accordance with the severity of the infraction and the number of times the infraction occurs, a child may (A) be suspended or (B) be terminated from the program for:

1. **Repeatedly using foul language and/or being rude and discourteous to staff and/or peers.**
2. **Defacing YMCA property.**
3. **Bringing or using illegal substances: alcohol, drugs, weapons (as deemed by staff of the YMCA) or unsafe personal sports equipment.**
4. **Stealing or defacing the property of others.**
5. **Refusing to remain with his/her group, intentionally and repeatedly leaving his/her group activity.**
6. **Inappropriate physical contact: repeated hitting, biting, other physical altercations.**
7. **Intentionally or repeatedly going to unauthorized areas of the facility or leaving the premises without permission will result in the following actions: a search of the premises will be conducted; if the child is not found, the police and parent/guardian will be notified and the child will not be allowed to return to Y-Care. No refund will be given.**
8. **Bullying of any kind will not be tolerated at all.**

In the event that a child has proven that he/she is unwilling to follow these policies, the parent/guardian will be notified and must meet with the Director of Youth Development & Family Engagement in order to discuss the situation. The Director will consider a possible suspension or termination. NO REFUNDS will be given. It is our daily desire that every child enjoys his/her YMCA experience. It is for this reason that we have initiated polices we feel are fair, easily complied with and are of benefit to everyone involved.

Parent signature: _____ Date: _____

Permission Agreements

Please read and initial the following permission statements indicating your agreement.

MOVIES

_____My child has permission to view G and PG rated movies at Bloomsburg Area YMCA. I understand that under no circumstances will a movie rated other than G or PG be shown during YMCA Y-Care Program.

PHOTOGRAPHS

_____I authorize the reproduction and use, for promotional purposes, of any photographic images taken of me and/or my child by the YMCA of Bloomsburg, Pennsylvania. I understand that I will not receive any compensation, money or otherwise, for the professional use of said photographic images.

_____I authorize the reproduction and use, for promotional purposes, of any photographic images taken of me and/or my child by the YMCA of Bloomsburg, Pennsylvania on Facebook and other social media. I understand that I will not receive any compensation, money or otherwise, for the professional use of said photographic images.

_____I do not want any photographic images taken of me and/or my child by the YMCA.

I understand, accept, and agree with the above statements as checked.
As proof of my understanding, acceptance and agreement, I have signed below.

Print Parent/Guardian Name: _____

Parent/Guardian Signature _____Date: _____

Child Health Assessment

Parents & Child Care Providers fill-in this part.

Child's Name: (Last)	(First)	Parent/Guardian:
Date of Birth:	Home Phone:	Address:
Child Care Facility Name:		
Facility Phone:	County:	Work Phone:

To Parents: Submission of this form to the child care provider implies consent for the child care provider to discuss the child's health with the child's clinician.

PA child care providers must document that enrolled children have received age appropriate health services and immunizations that meet the current schedule of the American Academy of Pediatrics 141 Northwest Point Blvd., Elk Grove Village, IL 60007. The schedule is available at <www.aap.org> or Faxback 847/758-0391 (document #9535 and #9807). Print copies provided by DPW have the schedule on the back of the form.

Health history and medical information pertinent to routine child care and emergencies (describe, if any): ☐ NONE	Date of most recent well-child exam:
Allergies to food or medicine (describe, if any): ☐ NONE	Do not omit any information. This form may be updated by health professional. (Initial and date new data.) Child care facility needs 2 copies.

Parents may write immunization dates, health professionals should verify and complete all data.

LENGTH/HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	BLOOD PRESSURE
_____IN/CM % ILE _____	_____LB/KG % ILE _____	(Birth to Age 2) _____IN/CM % ILE _____	(Beginning at age 3) _____ / _____

PHYSICAL EXAMINATION	☑ = NORMAL	If ABNORMAL - COMMENTS
Head/Ears/Eyes/Nose/Throat		
Teeth		
Cardiorespiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurologic & Developmental		

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
DTa/DTP/Td						
POLIO						
HIB						
HEP B						
MMR						
VARICELLA						
PNEUMOCOCCAL						
OTHER						

SCREENING TESTS	DATE TEST DONE	NOTE HERE IF RESULTS ARE PENDING OR ABNORMAL
LEAD		
ANEMIA (HGB/HCT)		
URINALYSIS (UA) (at age 5)		
HEARING (subjective until age 4)		
VISION (subjective until age 3)		
PROFESSIONAL DENTAL EXAM		

Health Problems or Special Needs, Recommended Treatment/Medications/Special Care (attach additional sheets if necessary)

☐ NONE

NEXT APPOINTMENT - MONTH/YEAR:

Medical care Provider:	Signature of Physician or CPNP:	
Address:		
Phone:	License Number:	Date Form Signed:

CY-51- 4/02

We build strong kids, strong families, and strong communities.

Dear Parents,

Please make sure your child's physician completes this form in its entirety, especially all screenings, signatures and dates. **This health assessment needs to be complete and returned within 30 days of enrollment in the Y-Care program. If we do not receive the health assessment by that date, then your child will be suspended from the program until the assessment is received.**

Thank You,
Serena Hampton
Director of Youth Development &
Family Engagement

Dear Health Care Provider,

This child is currently enrolled in our child care facility which is licensed and inspected by the Pennsylvania Bureau of Child Day Care Services. State regulations require enrolled children to have age appropriate health appraisals, including immunizations and health screenings according to the recommendations of the American Academy of Pediatrics.

Please help us to maintain compliance with these health regulations by completing the attached form according to AAP standards. Please be sure to sign and date the form as required by state regulations. Should you have any questions, please call the PA Chapter of AAP at 800-24-ECELS.

Thank you for your cooperation.

This note must remain attached to this health assessment.

Bloomsburg Area YMCA, 30 East 7th Street, Bloomsburg, PA 17815-2728
Phone: (570) 784-0188 / Fax: (570) 784-4303
A United Way Agency

SPECIAL NEEDS FORM

Child's name_____ Nickname_____

***Does your child qualify to receive Special Education Services through the schools?* __yes __no**

List any specific disabilities, allergies, or special health conditions of your child:

_____

_____

Does your child have heart trouble? ____yes _____no

If yes, please explain:

_____

Does your child have seizures? ____yes _____no

If yes, please state type, frequency, and procedure(s) to follow during and immediately following the seizure: _____

_____

Please describe your child's behavior prior to and after a seizure. _____

_____

Does your child use any special equipment? ___yes ___no

___ Wheelchair	**___Braces**	**___Crutches**	**___Canes**
___Walker	**___Hearing Aid**	**___Glasses**	**___Pacemaker**

Do you have any instructions? _____

_____

Does your child need any special assistance? ___yes ____no

If yes, please explain. _____

_____

Does your child have any communication difficulties? ___yes ___no

If yes, please explain including extent of difficulties and any methods used to compensate for difficulties (e.g. sign language, speech board, lip reading). _____

_____

If your child is deaf, does he/she require an interpreter? ___yes ___no

INDIVIDUALIZED EDUCATION PLANS (IEP) & INDIVIDUALIZED FAMILY SERVICE PLANS (IFSP) INFORMATION SHEET

Because of the diverse set of needs of the children in our program, it is important to gather as much information about the best ways to educate each child. IEP's and IFSP's are created by service providers working with children with special needs and include this information. The Keystone STARS Performance Standards therefore require each early learning provider to request copies of IEP's and IFSP's for the children in their care. Because of the importance of the IEP/IFSP to a child's learning, the program should have a copy before the child begins to attend, if possible.

The information found on an IEP/IFSP is protected by privacy lays including the Health Insurance Portability and Accountability Act (HIPAA).

Parent Sign-off Sheet

Child's Name: _____

Your child's growth and development is measured with developmental assessments. If your child currently has an IEP/IFSP, it would be beneficial to share a copy of this plan with us so we can work together to ensure that the guidelines are put into practice. You do not have to provide this information if you do not wish to do so.

☐ I am providing a copy of my child's IEP or IFSP.

☐ I am not providing a copy of my child's IEP or IFSP and/or this is not applicable to my child.

Signature: _____ Date: _____

Printed Name: _____

AGREEMENT

55 PA CODE CHAPTERS 3270.123 &.181(C); 3280.123 &.181(c); 3290.123 &.181(c)

NAME OF CHILD		
FEE AMOUNT $	PER-DAY-WEEK per week	DAY PAYMENT TO BE MADE Every Friday

Services to be provided as part of the day care fee (examples; transportation, care, meals, etc.)

CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
LATE FEE $ $5.00	PER MIN-HR Per 5 min	

Extra services to be provided at an additional fee if applicable

I, the parent/guardian;

☐ received complete written program information at the time of enrollment. (§ 3270.121, 3280.121, 3290.121)

☐ agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minumum. (§ 3270.124, 3280.124, 3290.124)

Serena Hampton

SIGNATURE-OPERATOR DATE

SIGNATURE-PARENT OR GUARDIAN DATE

DATE OF CHILD'S ADMISSION

DATE OF WITHDRAWAL

PERIODIC REVIEW

SIGNATURE-PARENT OR GUARDIAN DATE

PARENT COPY

We build strong kids, strong families, and strong communities.

SUBJECT: Nondiscrimination in Services

TO: Parents/Members

FROM: Serena Hampton, Director of Youth Development & Family Engagement

Admissions, the provisions of services, and referrals of clients shall be made without regard to race, color, religious creed, disability, ancestry, national origin (including limited English proficiency), age, or sex.

Program services shall be made accessible to eligible persons with disabilities through the most practical and economically feasible methods available. These methods include, but are not limited to, equipment redesign, the provision of aides, and the use of alternative service delivery locations. Structural modifications shall be considered only as a last resort among available methods.

Any individual/client/patient/student (and /or their guardian) who believes they have been discriminated against, may file a complaint of discrimination with:

Bloomsburg Area YMCA
30 East 7th Street
Bloomsburg, PA 17815
(570)784-0188

Department of Public Welfare
Bureau of Equal Opportunity
Room 223, Health & Welfare Building
PO Box 2675
Harrisburg, PA 17105

PA Human Relations Commission
Harrisburg Regional Office
333 Market Street, 8th Floor
Harrisburg, PA 17101

U.S. Dept. of Health & Human Services
Office for Civil Rights
Suite 372, Public Ledger Bldg.
150 South Independence Mall West
Philadelphia, PA 19106-9111

EMERGENCY CONTACT / PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124(a)(b), 3270.181 & 182 3280.124 (a)(b) 3280.181 & 182 3290.124 (a)(b), 3290.181 & 182

CHILD'S NAME	BIRTHDATE
ADDRESS	
MOTHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	
FATHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	

EMERGENCY CONTACT PERSON(S)	NAME	TELEPHONE NUMBER WHEN CHILD IS IN CARE

PERSON(S) TO WHOM CHILD MAY BE RELEASED	NAME	ADDRESS	TELEPHONE NUMBER WHEN CHILD IS IN CARE

NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER	TELEPHONE NUMBER
ADDRESS	
SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTION)
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICATION, SPECIAL CONDITIONS
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD	
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS	POLICY NUMBER (REQUIRED)

PARENT S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT

OBTAINING EMERGENCY MEDICAL CARE	**ADMIN. OF MINOR FIRST - AID PROCEDURES**
WALKS AND TRIPS	SWIMMING
TRANSPORTATION BY THE FACILITY	WADING

PERIODIC REVIEW

SIGNATURE OF PARENT or GUARDIAN — DATE

SIGNATURE OF PARENT or GUARDIAN — DATE

Child and Adult Care Food Program
Child Enrollment Form

Sponsor/Center Name: Bloomsburg Area YMCA
Agreement #: 311-49-138-7

ENROLLMENT FORM FOR CHILDREN IN CHILD CARE: This document does not have to be completed for children in Emergency Shelters, Outside School Hours, and/or At-Risk programs. It is recommended to have new CACFP Annual Enrollment Forms completed each year during the Household Eligibility Application renewal period. Review completed enrollment form and enter the effective date in lower right hand section.

PARENTS: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal regulations require all parents and guardians to complete a CACFP Annual Enrollment Form when enrolling their child(ren) and again every year thereafter. This information will help ensure all children receive appropriate meals during their care.

Please complete all areas, including signing and dating the yellow highlighted area:

FULL NAME OF FIRST CHILD (Include Birthdate/Age)	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FIRST NAME LAST NAME BIRTHDATE AGE	☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ DINNER ☐ EVENING SNACK
		☐ Yes ☐ No I work multiple shifts and my child(ren) may be in care different days/hours.								
		Other:								
		Enrollment Date:					**Withdrawal Date:**			
FULL NAME OF SECOND CHILD (Include Birthdate/Age)	**DAYS OF WEEK IN ATTENDANCE**	**TIMES CHILD NORMALLY ATTENDS DURING WEEK**								**MEALS RECEIVED**
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		☐ *Same Times as Above*								
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FIRST NAME LAST NAME BIRTHDATE AGE	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ DINNER ☐ EVENING SNACK
		☐ Yes ☐ No I work multiple shifts and my child(ren) may be in care different days/hours.								
		Other:								
		Enrollment Date:					**Withdrawal Date:**			
FULL NAME OF THIRD CHILD (Include Birthdate/Age)	**DAYS OF WEEK IN ATTENDANCE**	**TIMES CHILD NORMALLY ATTENDS DURING WEEK**								**MEALS RECEIVED**
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		☐ *Same Times as Above*								
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FIRST NAME LAST NAME BIRTHDATE AGE	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ DINNER ☐ EVENING SNACK
		☐ Yes ☐ No I work multiple shifts and my child(ren) may be in care different days/hours.								
		Other:								
		Enrollment Date:					**Withdrawal Date:**			

Signature: _____ _____ _____

Signature of Parent or Guardian *Date* *Best Contact (Phone) No.*

CHILD CARE REPRESENTATIVE USE ONLY: _____ _____

Name of Representative/Signature *Date*

The effective date can be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.

****

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. mail: U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Ave SW
   Washington, DC 20250-9410
2. fax: (833) 256-1665 or (202) 690-7442
3. email: program.intake@usda.gov

This institution is an equal opportunity provider.

CACFP Meal Benefit Income Eligibility (Child Care)

Complete one application per household. Please use a pen (not a pencil).

STEP 1 List ALL children in day care (if more spaces are required for additional names, attach another sheet of paper)

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related."

Children in Foster care and children who meet the definition of **Homeless, Migrant** or **Runaway** are eligible for free meals.

Child's First Name	MI	Child's Last Name	Foster Child	Migrant	Runaway	Homeless	Head Start
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐

Check all that apply

STEP 2 Do any household members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR?

IF NO > Go to STEP 3 **IF YES >** Write case number here and proceed to STEP 4 (do not complete STEP 3)

CASE NUMBER:

Write only one case number in this space.

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

The **"Sources of Income for Children"** chart will help you with the Child Income section.

The **"Sources of Income for Adults"** chart will help you with All Adult Household Members section.

A. Child Income

Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Children listed in STEP 1 here.

Child Income	How often? Weekly	Bi-Weekly	Monthly	Bi-Monthly
$	○	○	○	○

B. All Household Members (Including yourself)

List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Household Members (First and last)	Earnings from Work	How often? Weekly	Bi-Weekly	Monthly	2x Month	Welfare/Child Support/Alimony	How often? Weekly	Bi-Weekly	Monthly	2x Month	Pensions/Retirement/ Social Security/SSI/ VA Benefits	How often? Weekly	Bi-Weekly	Monthly	2x Month
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○

Total Household Members (Children and Adults)

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or other Adult Household Member X X X - X X - _ _ _ _

Check if no SSN ☐

STEP 4 Contact information and adult signature. This form is not valid without signature and date of adult household member

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Print Name of Adult Signing the Form | Signature of Adult | Today's Date

Address | City | State | Zip | Phone/Email

Source of Income for Children	
Sources of Child Income	**Examples**
Earnings from work	• A child has a regular full or part-time job where they earn a salary or wages
Social Security - Disability Payments - Survivors Benefits	• A child is blind or disabled and receives Social Security benefits • A parent is disabled, retired, or deceased, and their child receives Social Security benefits
Income from person outside of household	• A friend or extended family member reguarly gives a child spending money
Income from any other source	• A child receives regular income from a private pension fund, annuity, or trust

Source of Income for Adults		
Earnings from Work	**Public Assistance/Alimony/ Child Support**	**Pensions/Retirement/ All other sources of income**
• Salary, wages, cash bonuses • Net income from self-employment (farm or business) **If you are in the U.S. Military:** • Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) • Allowances for off-base housing, food, and clothing	• Unemployment benefits • Workers compensation • Supplemental Security Income (SSI) • Cash assistance from State or local government • Alimony payments • Child support payments • Veterans benefits • Strike benefits	• Social Security (including railroad retirement and black lung benefits) • Private Pensions or disability benefits • Income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • Regular cash payments from outside household

OPTIONAL Children's Ethnic and Racial Identities (Optional)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

MAIL*: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

FAX: (202) 690-7442; or
EMAIL: program.intake@usda.gov.

This institution is an equal opportunity provider.

***Only use this address if you are filing a complaint of discrimination.**

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Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

Total Income

How often? Weekly ○ Bi-Weekly ○ Monthly ○ 2x Month ○

Household size

Categorial Eligibility ☐

Eligibility: Free ○ Reduced ○ Denied ○

Determining Official's Signature

Date

Confirming Official's Signature (second check)

Date

Follow-up Official's Signature (For Pricing Institutions - Verification Official)

Date

Effective Date: If the Institution is using the parent/guardian signature date as the effective date, the form must have been signed by the Institution representative within the same month the parent signed the form or the immediately following month.