School Age Center Registration and Re-registration Information
Kindergarten – 5th Grade Children

NEEDED FOR REGISTRATION

-***ID Card*** (Military or DOD)

-***Program Information Form*** (1 per household), to initially set up the registration and to update/verify household information annually.

-***Health Screening Tool-1*** (1 per child Kindergarten – 5th grade), completed annually.

-***Child Health Assessment/Sports Physical*** (HA/SP) Form (1 per child Kindergarten – 5th grade), if complete at the time of registration (doctor - dated, signed, stamped; in addition to parent – date signature).

HA/SP are due within 30 days of registration for children Kindergarten through 5th grade. The sports physical portion is valid for one year and due before the first practice. Sports Physical must be valid through the entire sport season.

If child is currently enrolled in a full time before/after care/summer camp and/or at the center there is a valid health assessment on file, it may be able to be recertified for another year, this recertification can be completed at the center, if so. Sports Physicals cannot be recertified.

-***Child's Official Shot Record*** (fifth grade and below only if Homeschool or attending Private School)

If child is currently enrolled in a full time/part time before/after/camp program, the immunization records can be turned in/updated at the center. Anyone attending homeschool or private school must be fully up-to-date on all vaccinations in order to attend care.

-***Liability Waiver Form***

****

If enrolling or currently enrolled in full time before/after care/summer camp, please provide the following:

-***Proof of Parent(s) Income*** (i.e. Leave and Earnings Statement/Pay Vouchers. If spouse is a full time student, proof of enrollment is needed. Determination of DOD Fee Category for child care/school age fees is based on Total Family Income) 3 consecutive paystubs needed, unless ACTIVE DUTY. A *DOD Fee Application* will need to be completed at the time of enrollment and updated annually at re-registration.

-***Child/Adult Care Food Program Child Enrollment Form*** and ***Child Care Center Meal Benefit Income Eligibility Form***. Only needed for children in full time before/after care/summer camp enrollments. Initially completed at enrollment and updated annually.

-***Family Care Plans DA5305*** (Required for single/dual military and single/dual deployable civilian families) (Due 30 days from enrollment in part/full time programs). If at the center there is a valid Family Care Plan on file, it may be able to be recertified for another year, this recertification can be completed at the center, if so.

****

If the Health Screening Tool-1 has a "yes" designation on any of Parts B, C, D or E, additional medical forms will need to be obtained. Please contact Parent Central Services to receive additional forms. Most of these forms would require a dr. signature and could be completed at a health assessment/sports physical appointment. Typically these forms require annual updates.

Conditions that would require additional forms:

Diagnosed Behavior/Conduct concerns	Asthma/Respiratory Condition	Autism
Dietary Restrictions/Special Diet	Rescue Medication	Epilepsy/Seizures
Developmental Disability	ADD/ADHD	Diabetes
Allergies (Food, Medication)		

****

The following forms will be obtained at the Center and do not need to be completed at the time of registration:

-***CYS Acceptable Use Policy and Parental Acknowledgement***
-***McConnell Youth Center Code of Conduct***
-***Program Agreements***

Army Child, Youth and School Services (CYSS)

Program Information Form DATE:

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 10, United States Code, Section 3012. **PRINCIPAL PURPOSE(S)**: To provide child and family program eligibility, background information and sponsor consent for access to emergency medical care. **ROUTINE USES**: Information is furnished to the attending physician when it is necessary for an individual to be taken to a medical facility by someone other than the parent. **DISCLOSURE**: Disclosure of requested information is voluntary, however, if information is not provided, individual(s) may not be allowed to participate in the CYS Program. **DECLARATION OF NONDISCRIMINATION**: Services will be made available to all youth in attendance, without regard to race, religion, national origin, ancestry, or sex, within the limits of AR 608-10.

Sponsor's Name: _____ Grade/ Rank:_____

Status: Active Duty Guard Reserve DoD Civilian Eligible Contractor IF Student

Branch of Service: Army Air Force Navy Marine Corps Coast Guard

Installation Assigned (i.e. Carlisle Barracks, Letterkenny): _____

Employer: _____ Work Phone: _____

Home Address: _____ City,State,Zip: _____

Home Phone: _____ Cell Phone: _____ Live On-Post? ☐ Yes ☐ No

Sponsor's Email Address (AKO Preferred): _____

Spouse/Other Adult Contributor Name: _____ Grade/Rank:_____

Status: Active Duty Guard Reserve DoD Civilian Eligible Contractor Stay at Home Parent

Branch of Service: Army Air Force Navy Marine Corps Coast Guard

Employer: _____ Work Phone: _____

Cell Phone: _____ Spouse's/Alternate Email _____

Child's Name: _____ Grade: _____ School: _____
Child's Name: _____ Grade: _____ School: _____
Child's Name: _____ Grade: _____ School: _____
Child's Name: _____ Grade: _____ School: _____
Child's Name: _____ Grade: _____ School: _____

Emergency Contacts

(We need three local contacts, other than sponsor or spouse, authorized to respond in an emergency)

Name:_____ Home:_____ Cell:_____ Work:_____
Can your child/children be picked up by this person? ☐ Yes or ☐ No

Name:_____ Home:_____ Cell:_____ Work:_____
Can your child/children be picked up by this person? ☐ Yes or ☐ No

Name:_____ Home:_____ Cell:_____ Work:_____
Can your child/children be picked up by this person? ☐ Yes or ☐ No

5.A.01 Emergency Contacts

ARMY CHILD AND YOUTH SERVICES HEALTH SCREENING – TOOL #1

PRIVACY ACT STATEMENT

AUTHORITY:	10 U.S.C. 3013, Secretary of the Army; 29 U.S.C. 794, Nondiscrimination Under Federal Grants and Programs, DoDD 1342.17 Family Policy; AR 608-75, Exceptional Family Member Program: AR 608-10, Child Development Services; and E.O. 9397 (SSN).
PRINCIPAL PURPOSE:	Information will be used to assist Army activities in their responsibilities in overall execution of the Army's Exceptional Family member Program (EFMP) and the Army Child and Youth Services Program.
ROUTINE USES:	The DoD "Blanket Routine Uses" that appear at the beginning of the Army's compilation of systems of records apply to this system
DISCLOSURE:	Disclosure of requested information is voluntary; however; if information is not provided individual may not be able to participate in Army Child and Youth Services Program.

SNAP Case Number: _____

FOR CER COMPLETION ONLY

☐ Initial Registration
Is child on waiting list? ☐ Yes ☐ No
Date care needed? _____
☐ Re-registration/Child Already in Program
☐ Change in Program

Date in from Patron:

Date out to APHN:

Part A – General Information

Child/Youth Name	Child/Youth School Grade (example: 3rd Grade)	Date of birth (YYYYMMDD)	Age

Type of Placement Requested: (check all that apply)
☐ Hourly Care ☐ Full Day Care ☐ Middle School/Teen Program ☐ Summer Camp ☐ Other: (specify)
☐ Part Day Care ☐ Before/After School Care ☐ SKIES/Instructional Classes ☐ Sports

Sponsor Name	Sponsor E-mail	Best Contact Number
Spouse Name	Spouse E-mail	
Home Phone	Cell Phone	Sponsor Unit
Home Address		Sponsor Duty Phone

Part B – Identification of Child/Youth Condition/Restrictions

Does you child have any of the following conditions/restrictions: (check no or yes and answer questions as appropriate)

1. Allergies
   a. Life threatening reaction? ☐ No ☐ Yes
   b. Rescue Medication (Epi-pen, Benadryl, Inhaler) ☐ No ☐ Yes
   c. Does child/youth need rescue inhaler? ☐ No ☐ Yes
   If your child/youth has an allergy, please list: _____
   _____
   Reaction: _____
   _____
2. Special Diet ☐ No ☐ Yes
   a. Is your child on a complex diet (i.e. gluten free, diabetic) ☐ No ☐ Yes
   b. Does your child have a food intolerance/mild food allergy (i.e. rash from strawberries/milk intolerance)? ☐ No ☐ Yes
   c. Does your child have a dietary religious restriction? ☐ No ☐ Yes
3. Asthma/Reactive Airway Disease/Breathing Problems? ☐ No ☐ Yes
   a. Does your child need a rescue med? ☐ No ☐ Yes
4. Does your child have diabetes? ☐ No ☐ Yes
5. Does your child have seizures? ☐ No ☐ Yes
6. Attention Deficit Disorder (ADD/ADHD)
   a. Are there behavior/conduct concerns while on meds? ☐ No ☐ Yes
   b. List ADD/ADHD medications: _____
   _____
   _____
   _____
7. Behavior/ conduct concerns (oppositional defiant disorder, anxiety, depression, bipolar, other)? ☐ No ☐ Yes
8. Autism Spectrum Disorders (Autism, Aspergers, Rett Syndrome, PDD-NOS) ☐ No ☐ Yes
9. Does your child have any of the following health concerns? (circle all that apply)- Hearing impairment, vision impairment other than corrective lenses, heart, kidney, physical disability SEVERE skin condition ☐ No ☐ Yes
   Please specify _____
   _____
10. Does your child have a speech/language and/or hearing loss that affects their ability to communicate their basic needs (hurt, bathroom, fear, thirst)? ☐ No ☐ Yes
    Explain: _____
    _____
    _____
11. Does your child have developmental delays other than MILD speech language/MILD hearing loss? ☐ No ☐ Yes
    Explain: _____
    _____
12. Are there any other conditions or concerns that you would Like staff to be aware of? ☐ No ☐ Yes
    Explain: _____

Part C – Medications

List any medications that are prescribed for your child/youth other than those listed above:

Will your child require medication administration during child care/youth supervision hours? ☐ No ☐ Yes

Part D – Early Intervention and Special Education

Does your child/youth receive special services/therapies? ☐ No ☐ Yes
Please specify: _____

Does your child/youth have an Individualized Education Plan (IEP), Individualized Family Service Plan (IFSP) or 504 Plan? ☐ No ☐ Yes

Part E – Exceptional Family Member Program (EFMP) Enrollment

Is your child enrolled in the EFMP? ☐ No ☐ Yes If yes, specify for what condition: _____

_____ _____
Printed Name and Signature of Parent/Personal Representative of Child/Youth Date (YYYYMMDD)

If you have answered NO to all the questions above you are now finished with this form.
Please sign and date indicating that the information above is accurate and complete to the best of your knowledge.

Child, Youth and School Services strives to provide the safest and healthiest environment for your child/youth and relies on your accurate and honest information to support this goal. Please understand that placement and/or care for your child/youth could be delayed/suspended if information is falsified or intentionally omitted on registration documentation. If there are any changes to your child/youth's health please notify CYS Services immediately.

If you answered YES to any of the questions above, complete Part F on the next page.

Form Updated 11 Mar 09

Child/Youth Name	Date of birth (YYYYMMDD)	Age

Part F – Release of Information

I authorize _____(name of Medical Treatment Facility or physician's practice) to release any medical information regarding my child _____(name of child) to the _____ (name of installation) Child & Youth Services (CYS) Special Needs Accommodation Process (SNAP) personnel and their staff that is necessary to conduct SNAP review. This authorization will remain in effect for one year. I understand I may revoke this consent in writing at any time before expiration, but any action taken by the SNAP on this authorization prior to revocation is valid and will remain in effect.

I understand that information disclosed pursuant to this authorization is For Official Use Only (FOUO) and may be subject to redisclosure. I understand that information redisclosed is no longer protected by DoD 6025, 18-R; however, confidentiality of this information will remain protected by the Privacy Act of 1974, 5 U.S.C. section 552a.

The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.

_____ _____

Printed Name and Signature of Parent/Personal Representative of Child | Date (YYYYMMDD)

Part G – Army Public Health Nurse (APHN) Review

Current Medications other than those listed on page 1:

Diagnosis: _____

Background/Notes:

Medical Records Reviewed? ☐ No ☐ Yes ☐ Not Available

Training for CYS Staff/Provider Required:

Recommendation Summary:

SNAP REQUIRED: ☐ No SNAP required ☐ Modified ☐ Full ☐ Annual Review (No team meeting required)

Requirements Prior to Placement:

Medical Action Plan reviewed by APHN: ☐ Respiratory ☐ Allergy ☐ Seizure ☐ Diabetes ☐ Special Diet ☐ Other_____

APHN Printed Name or Stamp	APHN Signature	Date (YYYYMMDD)

Date Received by APHN	Date Returned to CER:

Form Updated: 11 Mar 09

HEALTH ASSESSMENT/SPORTS PHYSICAL STATEMENT (HASPS)
for CYS SERVICES
ENROLLMENT, Renewal & SPORTS PHYSICAL Requirements

Revised 08Jan 09

DATA REQUIRED BY THE PRIVACY ACT OF 1994

PRINCIPAL PURPOSE: Information is used by DA personnel to: (1) verify child health status of immunization per admission requirements; (2) note special program considerations or restriction on child participation; (3) execute emergency medical procedure for chronic illnesses/conditions; (4) refer child for enrollment in Exceptional Family Member Program; (5) certify physically fit to participate in sports. **ROUTINE USES:** No information is disclosed outside DOD. **DISCLOSURE:** Information is voluntary; however, if information is not provided, individuals may not be able to participate in community activities.

INSTRUCTIONS: All sections A, B, C. must be completed

PART: A Medical History (Filled out by parent / guardian)

Name of Sponsor	Home Telephone Cell Telephone	Duty/Work Telephone
Sponsor Unit / Work Address	Sponsor SSN XXX-XX-XXXX	Spouse's Work Telephone

CHILD HEALTH INFORMATION

Name of Child	Birth Date	Sex
		☐ Male ☐ Female

Does your child have ongoing medical concerns?
(If Yes, explain circumstances and current status)

☐ Yes ☐ No

Is your child enrolled in Exceptional Family Member Program?
(If Yes, explain)

☐ Yes ☐ No

MEDICAL HISTORY

	YES	NO		YES	NO
1. Any hospitalization or operations			14. Heat stroke or exhaustion		
2. Allergies to medicine, insect bites or food			15. Broken bones or sprains		
3. Speech or development delays			16. Joint injuries (Ankle/Knee/Wrist)		
4. Vision Problems (Glasses / Contacts)			17. Required restricted physical activity		
5. Ear or hearing problems			18. Diabetes		
6. Seizures or Convulsions			19. Cancer		
7. Dizziness or fainting with exercise			20. Dental or orthodontic braces		
8. Headaches			21. Learning problems		
9. Head injury or loss of consciousness			22. Sleep problems		
10. Neck or back injury			23. Behavioral problems		
11. Asthma or difficulty breathing			24. ADD / ADHD		
12. Heart or blood pressure problems			25. Autism Spectrum Disorder		
13. Chest pain with exercise			26. Other (please list below)		

If you answer yes to any of the above, please explain:

Ongoing Medications

Name	Dosage	Frequency

Allergies – All Types (Foods, Medicines and Insect Bites)

Type	Reaction

PART B: Physical Exam

Medical Staff Assessment (Completed by licensed independent practitioner: Doctor-Dr., Nurse Practitioner-NP, Physician's Assistant-PA)

Age YRS MOS	**Height** _____ cm. (_____ %ile)	**Weight** _____ kgs. (_____ %ile)
BP: / **P:**	**Visual Acuity** Right / Left / Tested with / without glasses	

	NORMAL	ABNORMAL	N / A	COMMENTS
1. Eyes				
2. Ears, Nose & Throat				
3. Hearing				
4. Mouth & Teeth				
5. Neck (Soft tissues)				
6. Cardiovascular				
7. Chest & Lungs				
8. Abdomen				
9. Genitalia – Hernia				
10. Skin & Lymphatics				
11. Spine – Scoliosis				
12. Extremities				
13. Neurological				
14. Wears braces / plates				

Based on this HX and PX exam, the following abnormalities were found and may need treatment:

Immunizations are current and up to date: ☐ Yes ☐ No

PARTICIPATION RECOMMENDATIONS

☐ All sports _____Yes _____ No ☐ Normal physical activity to including PE

☐ Additional comments: ☐ Restrictions:

Sports Physical is valid for 1 year from date indicated below

PART C

Special Medical Considerations: Describe any special program needs, considerations or restrictions which the child requires in order to participate in CYS programs (to include Sports).

Child / Youth is able to participate in normal CYS programs? ☐ Yes ☐ No

Date	**Licensed Health Care Professional Stamp**	**Licensed Health Care Professional; Dr., NP or PA Signature**

Initial Date	**Type or print name of Parent or Guardian**	**Signature of Parent or Guardian**

HASPS Renewal (Not Part of the Sports Physical)

Year 2 Date	**Health Status Changed**	**Signature of Parent or Guardian**
	☐ Yes ☐ No	
Year 3 Date	**Health Status Changed**	**Signature of Parent or Guardian**
	☐ Yes ☐ No	

"This document conforms to the privacy act of 1974: 10 USC 30 31"

LIABILITY WAIVER

USAG Carlisle Barracks CYS
459 Bouquet Rd
Carlisle Barracks
Carlisle PA 17013
Phone: (717)245-4555

Sponsor's Name:

Address:

Hm Ph:

Wk Ph:

Email:

Participant:

Guardian:

MEMORANDUM FOR RECORD
SUBJECT: Child and Youth Services (CYSS) Statements of Understanding and Medical Consent Statement

1. Data Required by the Privacy Act of 1974

2. Authority. Title 10, United States Code, section 3012.

3. Principal Purpose. Information is used by DA personnel to: (1) provide Child and Family program eligibility and background information, (2) develop programs meeting needs of Children and Families, (3) ensure appropriate placement of Child, (4) identify contingency plan for Child illness, (5) identify emergency designees, and (6) collect data required by USDA food program.

4. Routine Uses. Information on immunization and medical problems will be used as part of the program admission screening procedure. Family income data will be used to determine USDA food program qualification and rate structures. Medical consent information is furnished to the attending physician when it is necessary for a child to be taken to a medical facility by someone other than the parent.

5. Disclosure. Disclosure of requested information is voluntary. However, if information is not provided, individuals may not be allowed to participate in Child and Youth Services (CYS) programs.

6. Statements of Understanding.
   a. I have received the CYS Parent Handbook and will abide by all policies.
   b. I acknowledge that CYS facilities are under video surveillance.
   c. I have reviewed the Household and Family information file. To the best of my knowledge, the information provided to CYS is accurate and complete.
   d. I consent to the following in reference to the care of my child: Yes ☐ No ☐

   i. Participation in on/off post excursions accompanied by CYSS personnel with prior knowledge. Yes ☐ No ☐

   ii. Transportation in a government or commercial vehicle is authorized for field trips or emergency situations. Yes ☐ No ☐

   iii. Use of photographs of my child for release to the Installation newspaper, civilian media, or to copyright and/or reuse in other military or civilian publications or on the Installation websites. Yes ☐ No ☐

7. Medical Consent Statement.
   a. I give consent by signing this agreement, for an authorized Child and Youth Services (CYS) representative to take my Child for care, medical or dental, in an emergency situation when the child's condition represents a serious or imminent threat to his/her life, health, or well-being.
   b. I understand that a conscientious effort will be made to notify me before such action.
   c. I will pay any expenses incurred.
   d. Treatment at an Army medical facility may be provided without additional consent under provision of AR 40-3, paragraph 2-24b.

_____ _____

PARENT SIGNATURE DATE

Child and Adult Care Food Program
Child Enrollment Form

Sponsor:_____
Center:_____

ENROLLMENT FORM FOR CHILDREN IN CHILD CARE (SAMPLE)

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 CACFP 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 to include signing and dating same.

FULL NAME OF ENROLLED CHILD (Include Birth Date/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 CHILD	☐ MONDAY									
NAME	☐ TUESDAY ☐ WEDNESDAY	☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								☐ BREAKFAST
	☐ THURSDAY	Other:								☐ A.M. SNACK
BIRTH DATE	☐ FRIDAY									☐ LUNCH
	☐ SATURDAY									☐ P.M. SNACK
AGE	☐ SUNDAY									☐ SUPPER
		Enrollment Date:			**Withdrawal Date:**					☐ EVENING SNACK
FULL NAME OF ENROLLED CHILD (Include Birth Date/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	
SECOND CHILD	☐ *Same as Above*									☐ *Same Meals as Above*
	☐ MONDAY									
NAME	☐ TUESDAY ☐ WEDNESDAY	☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								☐ BREAKFAST
	☐ THURSDAY	Other:								☐ A.M. SNACK
BIRTH DATE	☐ FRIDAY									☐ LUNCH
	☐ SATURDAY									☐ P.M. SNACK
AGE	☐ SUNDAY									☐ SUPPER
		Enrollment Date:			**Withdrawal Date:**					☐ EVENING SNACK
FULL NAME OF ENROLLED CHILD (Include Birth Date/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	
THIRD CHILD	☐ *Same as Above*									☐ *Same Meals as Above*
	☐ MONDAY									
NAME	☐ TUESDAY ☐ WEDNESDAY	☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								☐ BREAKFAST
	☐ THURSDAY	Other:								☐ A.M. SNACK
BIRTH DATE	☐ FRIDAY									☐ LUNCH
	☐ SATURDAY									☐ P.M. SNACK
AGE	☐ SUNDAY									☐ SUPPER
		Enrollment Date:			**Withdrawal Date:**					☐ EVENING SNACK
FULL NAME OF ENROLLED CHILD (Include Birth Date/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	
FOURTH CHILD	☐ *Same as Above*									☐ *Same Meals as Above*
	☐ MONDAY									
NAME	☐ TUESDAY ☐ WEDNESDAY	☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								☐ BREAKFAST
	☐ THURSDAY	Other:								☐ A.M. SNACK
BIRTH DATE	☐ FRIDAY									☐ LUNCH
	☐ SATURDAY									☐ P.M. SNACK
AGE	☐ SUNDAY									☐ SUPPER
		Enrollment Date:			**Withdrawal Date:**					☐ EVENING SNACK
FULL NAME OF ENROLLED CHILD (Include Birth Date/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	
FIFTH CHILD	☐ *Same as Above*									☐ *Same Meals as Above*
	☐ MONDAY									
NAME	☐ TUESDAY ☐ WEDNESDAY	☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								☐ BREAKFAST
	☐ THURSDAY	Other:								☐ A.M. SNACK
BIRTH DATE	☐ FRIDAY									☐ LUNCH
	☐ SATURDAY									☐ P.M. SNACK
AGE	☐ SUNDAY									☐ SUPPER
		Enrollment Date:			**Withdrawal Date:**					☐ EVENING SNACK

Signature _____ _____ _____

Signature of Parent or Guardian *Date* *Telephone Number of Parent or Guardian*

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.

Child and Adult Care Food Program
Child Care Center Meal Benefit Income Eligibility Form

Part 1. All Household Members

Names of Enrolled Child(ren) (First, Middle Initial, Last)	Check if a foster child (the legal responsibility of a welfare agency or court) * If all children Listed below are foster children, skip to Part 5 to sign this form.	Check if NO income
	☐	☐
	☐	☐
	☐	☐
Names of all Household Members (First, Middle Initial, Last)		
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Part 2. Benefits: If any member of your household received [State SNAP], [FDPIR], or [State TANF cash assistance], provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**
NAME:_____ CASE NUMBER: ___ ___ - ___ ___ ___ ___ ___ ___ ___

Part 3. If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call **[Your center director, Homeless Liaison, Migrant Coordinator at Phone #]** Homeless ❑ Migrant ❑ Runaway❑

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List **only** household members with income)	**B. Gross income and how often it was received**			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$_____/_____
	$_____/N/A	$_____/N/A	$_____/N/A	$_____/N/A
	$_____/N/A	$_____/N/A	$_____/N/A	$_____/N/A
	$_____/N/A	$_____/N/A	$_____/N/A	$_____/N/A
	$_____/N/A	$_____/N/A	$_____/N/A	$_____/N/A
	$_____/N/A	$_____/N/A	$_____/N/A	$_____/N/A

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign Here: _____ Print Name: _____ Date: _____

Address: _____ City:_____ State: _____ Zip Code: _____

Phone Number: _____

Last four digits of Social Security Number: _*_*_*-_*_*-____ ❑ I do not have a Social Security Number

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:

- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino

Mark one or more racial identities:

- ❑ Asian
- ❑ White
- ❑ Black or African American
- ❑ American Indian or Alaska Native
- ❑ Native Hawaiian or Other Pacific Islander

Don't fill out this part. This is for official use only.

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

Total Income: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

Categorical Eligibility: _____ Eligibility: Free_____ Reduced_____ Denied (Paid)_____ Date Withdrawn: _____

Reason for Denied: _____

Temporary: Free_____ Reduced_____ Time Period: _____(expires after _____ days)

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date: _____

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

Household size	Yearly
1	$20,665
2	$27,991
3	$35,317
4	$42,643
5	$49,969
6	$57,295
7	$64,621
8	$71,947
Each additional person:	+$7,326

Privacy Act Statement: 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, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. 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 for the participant or other (FDPIR) identifier 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 if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."