RE-REGISTRATION

Parent Central Services Registration Checklist
Moore Child Development Center

Phone: 717.245.3701

455 Fletcher Rd.

Children/Youth must be fully registered before they can use any CYS Services Program.

To expedite the registration process, please have the following information available.

ITEMS/INFORMATION TO BRING TO REGISTRATION APPOINTMENT	VERIFICATION
ID Card (Military or DOD)	
Child's Official Shot Record (fifth grade and below, Homeschool, and Private School)	
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)	
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	
Program Agreement	
Current Health Insurance Form/Emergency Contacts	
Health Screening Tool-1 (To record/evaluate child's allergies, medical/physical conditions, etc. for all children birth through 5th grades and ALL Youth identified as having special needs)	
Medical Action Plan (MAP) Only needed if a child is **diagnosed** with allergies, diabetes, asthma/respiratory or seizures that requires staff to give rescue medications) (If recommended by Special Needs Assessment Team) (New Medical Action Plans are required yearly at re-registration)	
Child/Ault Care Food Program Child Enrollment Form	
Child Care Center Meal Benefit Income Eligibility Form	
Liability Waiver Form	

Comments:_____

_____

_____

_____

_____

Registration completed by:_____ Date:_____

CHILD DEVELOPMENT SERVICE (CDS) SPONSOR/PROGRAM AGREEMENT

For use of this form, see AR 608-10; the proponent agency is DCS, G-1.

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 10, United States Code, Section 3013

PRINCIPAL PURPOSE: Information is used by DA personnel and patrons to: (1) Identify and clarify responsibilities of all parties involved in agreement, (2) specify commitment regarding acceptance and provision of CDS services.

ROUTINE USES: Information provided may be released IAW the Army's blanket routine uses contained in AR 340-21.

DISCLOSURE: Disclosure of requested information is voluntary; however, if information is not provided, individuals may not be able to participate in CDS programs.

NAME OF SPONSOR *(Last, first, MI)*

PROGRAM: Carlisle, CDC

VALID FROM *(Month, day, year to month, day, year)*:

SERVICE *(Check appropriate box)*

☐ FULL DAY ☐ PART DAY PRESCHOOL ☐ PART DAY SCHOOL AGE ☐ FCC HOME ☐ HOURLY

AGE GROUP CATEGORY *(Check appropriate box)*

☐ INFANT ☐ TODDLER ☐ PRESCHOOL AGE ☐ SCHOOL AGE

I agree to enroll my child/children _____

in the Moore Child Development Center

CDS Facility/Family Child Care Home located at

455 Fletcher Road

PROGRAM SERVICES

PROGRAM OPERATING HOURS ARE AS FOLLOWS (List hours) (CDS personnel)

MON 0630 TO 1730 TUES 0630 TO 1730 WED 0630 TO 1730

THURS 0630 TO 1730 FRI 0630 TO 1730 SAT _____ TO _____

SUN _____ TO _____

*SERVICES FOR MY CHILD/CHILDREN WILL BE AS FOLLOWS (List hours) (Sponsor)

MON _____ TO _____ TUES _____ TO _____ WED _____ TO _____

THURS _____ TO _____ FRI _____ TO _____ SAT _____ TO _____

SUN _____ TO _____

SERVICES WILL NOT BE AVAILABLE ON *(List time/date) (CDS personnel)*

*Authorized Closure (no fee adjustment) I WILL BE NOTIFIED IN ADVANCE, WHENEVER POSSIBLE, OF ADDITIONAL PERIODS OF NON-SERVICE AS DETERMINED BY CDS PERSONNEL.

(CHILD MAY BE DENIED CARE WHEN ILLNESS PRECLUDES PARTICIPATION IN ROUTINE PROGRAM ACTIVITIES)

PRIOR NOTICE REQUIREMENT *(List amount of time required to terminate services) (CDS Personnel)*

Failure to provide two weeks advance notice for cancellation will result in the weekly fee charge to the household.

UNIQUE CONSIDERATIONS *(Sponsor)*

I REQUEST THE FOLLOWING SPECIAL NEEDS OF MY CHILD/CHILDREN AS ACCOMMODATED

MY CHILD/CHILDREN REQUIRES THE FOLLOWING SPECIAL ITEMS WHICH I WILL SUPPLY

*NON APPLICABLE FOR HOURLY SERVICES

FEES AND CHARGES *(CDS Personnel)*

RATES FOR PROGRAM SERVICES ARE AS FOLLOWS:

Fee Category:_____ Bi-Monthly Tuition:_____ or Monthly Tuition: _____

Part Day Tuition: _____ Hourly: $5.00 hour up to 15 hours a week on space available basis.

I understand that I am choosing not to provide my Pay/LES and I understand I will be placed in CAT 9. _____

MISCELLANEOUS FEES FOR PROGRAM SERVICES ARE AS FOLLOWS:

Late fee payments are $10.00 per child for monthly (Full day) and a one time late fee of $20.00 for monthly (Part Day). These fees will be assessed on the 6th business day. Late Pick-up Fees are $1.00 per minute for the first 15 minutes, then $5.00 for the next 45 minutes. Lare pick up fees are accessed per site. Return Check Fee is $25.00

AN OVERTIME/LATE FEE OF $ 1.00 per minute WILL BE CHARGED STARTING AT 1730 HOURS.

*PAYMENT OBLIGATION IS BASED ON HOURS I AGREE TO USE SERVICES NOT ON ACTUAL HOURS OF CHILD ATTENDANCE, UNLESS THEY EXCEED THE HOURS CONTRACTED.

*IN THE EVENT OF ABSENCE OF MY CHILD/CHILDREN FROM CARE DUE TO ILLNESS, FEES WILL/WILL NOT BE REDUCED.

*IN THE EVENT OF ABSENCE OF MY CHILD/CHILDREN FROM CARE DUE TO VACATION, FEES WILL/WILL NOT BE REDUCED.

FEES WILL BE PAID IN THE FOLLOWING MANNER

Hourly Care fees will be paid daily upon pick up.

Part Day Preschool/Pre-Kindergarten fees will be paid monthly in advance.

Full Day fees will be paid bi-monthly or monthly in advance.

Note: Full Day fees include 10 days of Non-Paid Child Care Leave

FEES AND CHARGES ARE SUBJECT TO CHANGE. PATRONS WILL BE NOTIFIED OF CHANGES 30 DAYS PRIOR TO EFFECTIVE DATE.

POLICIES *(CDS Personnel)*

*CHILD MEDICATION WILL BE ADMINISTERED ONLY UPON MY WRITTEN REQUEST UNDER THE FOLLOWING CDS CONDITIONS

Medication Administration is authorized in Full Day Care only. Medication must be prescribed. Physician or parents must administer first dose. Children will be on oral medication for 24 hours before dosage is administered by CDS Personnel. DA Form 5225-R (CDS Medical Dispensation Record) must be completed prior to administration of medication. Only physician prescribed medications are permitted within CDC programs.

LAUNDERING CHILD'S/CHILDREN'S SOILED CLOTHING WILL/WILL NOT BE DONE ON A ROUTINE BASIS.

I WILL PROVIDE THE FOLLOWING TO MEET CDS PROGRAM REQUIREMENTS

CDS Requirements:

-Provide daily telephone numbers for emergency notification.

-Provide Health Assessment within 30 days of registration (if no specials needs)

-Provide Family Care Plan within 30 days of registration (single/dual military)

-Provide Notifications of Immunizations (if applicable)

I ACKNOWLEDGE A SHARED RESPONSIBILITY WITH CDS FOR CHILD ABUSE PREVENTION

Child abuse prevention is a shared responsibility of parents and CDS staff. We will work cooperatively to keep each other informed on a daily basis and maintain open communication on behalf of the child's health and welfare. CDS has an open door policy and welcomes visits by parents. IAW AR608-10, Para 2-20 and and AR 608-18, all CDS employees are mandated to report ALL suspected child abuse.

I ACKNOWLEDGE AND CONSENT TO THE FOLLOWING CDS POLICIES CONCERNING THE CARE OF MY CHILD

A parent handbook is provided. Parents must ensure the understanding and compliance with policies and procedures. As changes occur, you will be given updated statements. Parents will be notified daily of any unusual occurrences concerning their children.

Children are accepted on a trial basis not to exceed 30 days from the first date of attendance. If at any time during that period, it is determined by CDS that the child's needs cannot be accommodated in the CDS delivery systems, the Outreach Services Director will assist in referral.

*All CDS program closures correspond with the direction and guidance from the Garrison Commander's Office. For 24 hour status updates on closures, please call 717-245-3700. Fee adjustments will NOT be made due to holidays, closures, or delays.

SIGNATURE OF SPONSOR	DATE
SIGNATURE OF CDS REPRESENTATIVE OR FCC PROVIDER	DATE

Current Health Insurance Information

Sponsor's Name:_____

Name of Insurance Company: _____

Policy Number:_____

5.A.01 Insurance Information

☐ No Insurance

☐ Parent/Sponsor does not wish to provide insurance information

Signature of Parent/Sponsor

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

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.

This portion of the form can be used to capture multi-year annual updates.

****

Annual Time Period Covered by Signature: ________________ **to** ________________

Signature Parent/Guardian________________________________ **Date** ______________

Signature Center Administrator/Home Provider____________________ **Date** ______________

****

Annual Time Period Covered by Signature: ________________ **to** ________________

Signature Parent/Guardian________________________________ **Date** ______________

Signature Center Administrator/Home Provider____________________ **Date** ______________

****

Annual Time Period Covered by Signature: ________________ **to** ________________

Signature Parent/Guardian________________________________ **Date** ______________

Signature Center Administrator/Home Provider____________________ **Date** ______________

****

Annual Time Period Covered by Signature: ________________ **to** ________________

Signature Parent/Guardian________________________________ **Date** ______________

Signature Center Administrator/Home Provider____________________ **Date** ______________

****

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing 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.

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
	☐	☐
Marinol	☐	☐
	☐	☐
Names of all Household Members (First, Middle Initial, Last)		
mar	☐	☐
	☐	☐
	☐	☐
	☐	☐

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
marinol igarta	$_____/N/A	$_____/N/A	$_____/N/A	$_____/N/A
marinol	$_____/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: bnDFnb Date: FB

Address: _____ City: zdnfz State: zfngz Zip Code: zgnz

Phone Number: zngz

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."

"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