



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

FIND YOUR AFTER SCHOOL SPOT. FIND YOUR Y.

Primetime Before & After School

The Y's before and after school programs employ a mission oriented team that is actively engaged and responsible to work with your child. Based in area elementary schools, students in grades K thru 6th are nurtured in a comfortable, thought-provoking childcare environment. Primetime is not a drop-in program, children must be enrolled in the program.

Sites

Lowman Hill Elementary, 1101 SW Garfield Ave
Berryton Elementary, 2921 SE 69th St
Shawnee Heights Elementary, 2410 SE Burton St

Drop Off/Pick Up Time

Children can be dropped off at 7:00AM and must be picked up by 6:00PM

Pricing

Morning Only: \$10.00/day | Afternoon Only: \$15.00/day
Morning & Afternoon: \$25.00/day

School Day Out Camp

This program offers daily childcare options for elementary-aged students in grades K thru 6th during days that school is out—teacher in-service, fall break, spring break. The program is at the YMCA of Topeka where student's needs are balanced with learning, physical activities, and social interaction.

Hours

7:00AM—6:00PM

Pricing

Y-Members: \$27.00/day | Non-Members: \$30.00/day

For questions regarding Primetime or School Day Out contact:

Terry Jones, Youth Services Director
p. 785.435.8651 e. terryj@ymcatopeka.org

For billing questions please contact us by phone at 785.435.8632 or by email at childcare-billing@ymcatopeka.org.

YMCA OF TOPEKA

3635 SW Chelsea Dr, Topeka, KS 66614
P. 785.271.7979 w. www.ymcatopeka.org





YMCA Primetime Before & After School / School Day Out Camp School Aged Program Enrollment Form

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Account Number:

School or Program <input type="checkbox"/> Lowman Hill <input type="checkbox"/> Berryton <input type="checkbox"/> Shawnee Heights <input type="checkbox"/> School Day Out Camp	Desired Start Date: ___ / ___ / ____
Desired Primetime Session <input type="checkbox"/> Before (AM) <input type="checkbox"/> After (PM) <input type="checkbox"/> Both (AM & PM)	Desired days of the week <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri

Child's Information

Child's Name	Date of Birth ___ / ___ / ____	Gender	Entering Grade
Child's Home Address	City, State Zip		Age

Parent/Guardian's Information

Relationship to Child <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____			
Name	Date of Birth ___ / ___ / ____	Gender	Cell Phone
Home Address	City, State Zip		Work Phone
Custodial Parent: <input type="checkbox"/> Yes <input type="checkbox"/> No	May the Y release to non-custodial parent? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other _____			
Email Address	Preferred Method of Communication <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> All		

Parent/Guardian's Information

Relationship to Child <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____			
Name	Date of Birth ___ / ___ / ____	Gender	Cell Phone
Home Address	City, State Zip		Work Phone
Custodial Parent: <input type="checkbox"/> Yes <input type="checkbox"/> No	May the Y release to non-custodial parent? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other _____			
Email Address	Preferred Method of Communication <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> All		

Emergency Contact/Authorized Pick Up

Relationship to Child			
Name	Date of Birth ___ / ___ / ____	Gender	Cell Phone
Home Address	City, State Zip		Work Phone

Additional Authorized Pick Up

Name	Date of Birth __ / __ / ____	Gender	Cell Phone
Home Address	City, State Zip		Work Phone

Additional Authorized Pick Up

Name	Date of Birth __ / __ / ____	Gender	Cell Phone
Home Address	City, State Zip		Work Phone

Additional Authorized Pick Up

Name	Date of Birth __ / __ / ____	Gender	Cell Phone
Home Address	City, State Zip		Work Phone

Additional Authorized Pick Up

Name	Date of Birth __ / __ / ____	Gender	Cell Phone
Home Address	City, State Zip		Work Phone

Statement of Understanding

- I will notify the YMCA of Topeka of any changes in the registration information.
- I understand it is my responsibility to sign my child in upon arrival to the program and out before leaving the program each day.
- I understand there is a \$1/minute late pick up fee charged for each child picked up after 6:00PM. If the child is not picked up by 7:00PM, local law enforcement will be notified.
- I understand that the YMCA of Topeka has a no outside contact policy between staff and children. This includes, but is not limited to: babysitting, sleepovers, transportation or other non-Y events.
- I understand that state law mandates the YMCA of Topeka to report any suspected cases of child abuse or neglect to the appropriate authorities for investigation.
- **In the event that I cannot be reached to make arrangements for emergency medical attention at the time of illness or accident, I hereby authorize the YMCA of Topeka to seek necessary medical attention.**
- I understand the YMCA may photograph/video tape for marketing purposes and release the YMCA from any claim or liabilities related to the use. I give my permission for the use of any photographs, videotapes, or other media recording of myself/my child's participation at the YMCA of Topeka for any lawful purpose, without compensation to me or on my behalf. If I choose not to have myself/my child photographed, videotaped, or in other record media, it is my responsibility to inform the photographer and remove myself/my child from the area.
- By participating in any activity or program under the YMCA Nationwide Membership Program, I agree to release the National Council of Young Men's Christian Associations of the United States of America, and its independent and autonomous member associations in the United States and Puerto Rico, from claims of negligence of bodily injury or death in connection with the use of YMCA facilities, and from any liability for other claims, including loss of property, to the fullest extent of the law. I/we, on behalf of myself/ourselves, and guests, agree to adhere to all policies set by the YMCA.

Print Legal Name	Relationship to Child
Signature	Date __ / __ / ____
Name of person who completed health history if different than parent/guardian	Relationship to Child



YMCA Primetime Before & After School / School Day Out Camp School Day Out Enrollment Worksheet

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Account Number:

Fill out this worksheet in addition to the "School Aged Program Enrollment Form" if you would like to enroll your child in School Day Out Camp.

School District (Please select one) <input type="checkbox"/> Topeka Public Schools <input type="checkbox"/> Shawnee Heights <input type="checkbox"/> Other: _____

Child's Information

Child's Name	Date of Birth __ / __ / ____	Gender
Child's Home Address	City, State Zip	

Date Selection

Provide the dates of each school day off you want to enroll your child for. Each day should be listed individually. School Day Out Camp is only offered on days that school is not in session.

Monday	Tuesday	Wednesday	Thursday	Friday

Print Legal Name	Relationship to Child
Signature	Date __ / __ / ____



Account Number: _____

Program Payment Agreement

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Accounting Policies

Initial

- _____ Acceptable payment form is: scheduled payment by electronic funds transfer (EFT) or pay-in-full by cash
- _____ Drafts will be made on Friday for the following week. **Drafts will be made each week unless two-week written notification has been provided for cancellation.**
- _____ The YMCA of Topeka does not issue statements for individual tax purposes. Please keep any and all cancelled checks, payment receipts or bank statements as documentation of childcare payments.
- _____ No adjustments in the weekly fee will be made for partially attended weeks.
- _____ If your payment is returned for insufficient funds (NSF), your payment along with an NSF service fee of \$30 will be collected electronically. **Any change to your billing information must be received at least seven (7) days prior to the date the change is to take effect.** A \$10 late fee will be assessed on payments not made by the deadline.
- _____ If full payment arrangement is not received, I understand that my child will be considered unregistered from any Y program they are currently enrolled in and unable to attend until the arrangement is received.

Payment Information

Parent's Name	Date of Birth __ / __ / __
Child's Name	Date of Birth __ / __ / __
Child's Name	Date of Birth __ / __ / __

- I will be making advanced payment in full at the YMCA of Topeka at the time of registration.
- I will make payment by electronic funds transfer (EFT) and have attached a voided check or bank letter.
 Bank Name: _____ Bank City/State: _____
 Type of Account: Checking Savings Name on Account: _____
 Routing Number: _____ Account Number: _____
- I will make payment by credit card. Visa Mastercard Discover American Express
 Card Number: _____ Expiration: __ / __ CVV2: _____
 Name on card: _____ Zip: _____
- I receive third-party payments (i.e. DCF/SRS, KVC, etc). **Approval letter from agency must be received prior to attending.** I understand that I am responsible for all copayment. **Fees and payments will not be determined by time sheets.**

I have read and agree to comply with all payments and accounting policies of the YMCA of Topeka.

Responsible Party for Billing Purposes	Responsible Party Signature	Date __ / __ / __
Email Address	Phone	
Authorized Party	Authorized Signature	Date __ / __ / __



YMCA Primetime Before & After School / School Day Out Camp Disciplinary Policy and Procedure

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Discipline procedures and policies are a very important part of daycare and youth experience. These policies will help children learn how to get along in the world, enjoy being with other children, and follow the direction of an adult other than their parent. A caring and positive approach will be taken regarding behavior management and discipline. Teachers will focus on positive behaviors of the children and reinforce those behaviors as often as possible. Our goal is to help children develop self-control and responsibility for their actions. Our disciplinary procedures are comprised of the following strategies:

- Encouraging children to use their words when having a disagreement with another child.
- Redirecting behavior.
- Separating a child from the group (i.e. "time out")—one minute for each year of age.
- Counseling children individually about their behaviors.
- Making parents aware of disciplinary concerns (i.e. Incident Report).

The following behaviors are examples of disruptive behavior:

- Requires constant attention from the staff.
- Inflicts physical or emotional harm on other children, adults, or self.
- Disrespects people and materials provided in the program.
- Consistently disobeys the rules of the classroom.
- Verbally threatens other students and/or staff.
- Uses verbal or physical activity that diverts attention away from the group of children.

Disruptive behavior will be addressed in an incident report. This will be completed to document any inappropriate behaviors that directly impact other children, staff members, or the group.

Informal Discussion

Before taking formal disciplinary action, the YMCA staff will make every effort to resolve the matter by informal discussion with the child/student and parent. If this fails to bring about the desired improvement or if the action(s) warrant, the formal disciplinary procedure may be implemented.

Formal Discipline

If conduct or behavior continues past an informal discussion or is serious enough to warrant formal discipline, the child/student will progress through these levels of formal discipline. Depending on the severity of the behavior or actions, steps may be skipped.

- Verbal warning
- Written warning
- Suspension
- Dismissal

Gross Misconduct

A child/student may be immediately dismissed or suspended without notice on grounds of gross misconduct. Fighting, leaving the site without permission, stealing, attacking or striking staff, bringing weapons, drugs, or illegal materials of any kind may all be considered gross misconduct.

By signing below, child/student(s) and parents understand and agree to abide by the written policies as stated within this document.

Parent Name	Parent Signature	Date __ / __ / __
Parent Name	Parent Signature	Date __ / __ / __



**MEDICAL RECORD FOR ALL CHILDREN IN CHILD CARE FACILITIES,
INCLUDING PROVIDER'S OWN CHILDREN**

Parents are to complete the Medical Record and the History of Immunizations for each child in licensed child care facilities. The Medical Record, History of Immunizations, and Child Health Assessment are transferable when the child moves to another licensed child care facility.

Child's First Day in Child Care _____

Name of Child Care Facility _____

Child's Name _____
First Last

Date of Birth _____ Gender _____
MM/DD/YYYY M/F

Parent/Guardian Information

Parent/Guardian Information

Name _____

Name _____

Home Address _____
Street City Zip Code

Home Address _____
Street City Zip Code

Home Phone Number _____

Home Phone Number _____

Employer _____

Employer _____

Work Phone Number _____

Work Phone Number _____

Cell Phone Number _____

Cell Phone Number _____

E-mail Address _____

E-mail Address _____

Best way to contact _____

Best way to contact _____

Persons authorized to pick up the child or to notify in case of emergency (other than the parents):

Name _____
Address _____
Phone Number _____

Name _____
Address _____
Phone Number _____

Child's Physician _____

Phone Number _____

Child's Dentist _____

Phone Number _____

Hospital Preference (for emergencies) _____

Has your physician approved the use of any non-prescription medications for your child such as acetaminophen, cough syrup, or ointments that can be given by the child care provider? No Yes, as follows: _____

Any known allergies or medical conditions of child:

Any major changes at home that might affect your child in care:

Please provide additional information or special instructions that will help the person caring for your child:

Parent/Guardian Signature: _____ Date: _____

History of Immunizations

Required for all children in child care facilities, including the provider's own children. A Kansas Certificate of Immunizations (KCI) may be substituted for this form and attached to the completed Medical Record.

Child's Name: _____ Date of Birth: _____
First Last MM/DD/YYYY

Section I. For a recommended schedule of immunizations, refer to the current schedule published by the Advisory Committee on Immunization Practices (ACIP).

Vaccine	Record the Month, Day and Year that each Dose of Vaccine was Received					
	1 st	2 nd	3 rd	4 th	5 th	6 th
Diphtheria, Tetanus, Pertussis (DTaP)						
Poliomyelitis (IPV/OPV)						
Measles, Mumps, Rubella (MMR)						
Hepatitis B (HepB)						
Varicella (VAR)			Hx of Disease: Physician Signature		Date of Illness:	
Hemophilus Influenzae Type B (Hib)						
Pneumococcal Conjugate (PCV)						
Hepatitis A (HepA)						
Rotavirus **Recommended <8 mo of age; not required						
Influenza(Flu) ** Recommended annually >6 mo of age; not required						

Section II.

Complete this section only if your child is exempted from the law requiring immunizations [K.S.A. 65-508(g)].

The following two options are the **ONLY** exemptions allowed by law. **Please check either (A) or (B) below and complete as required:**

(A) Certification from licensed physician stating that immunization would endanger child's life:

Exempt from following immunizations:

____DTaP/DT ____Tdap/TD ____Pertussis Only ____Polio ____MMR ____HepA ____HepB ____Hib
 ____PCV ____Varicella ____Other

Physician's Signature (required): _____ **Date:** _____

(B) My child is exempt under the law from immunizations. As the Parent or Legal Guardian, I state that I am an adherent of a religious denomination whose teachings are opposed to immunizations.

Section III.

Parent/Guardian Signature: _____ **Date:** _____

Child Health Assessment

The Child Health Assessment form is to be completed and signed by a nurse approved by KDHE to perform Child Health Assessments or a Licensed Physician. If a Physician Assistant (PA) completes the Child Health Assessment, the signature of the Licensed Physician authorizing the PA is to be included at the bottom of this form.

A Child Health Assessment, recorded on a KDHE Form or other acceptable Forms mentioned below, is required for all children including children of the provider or staff in Licensed Day Care Homes, Group Day Care Homes, Child Care Centers and Preschools. A Kan-Be-Healthy Assessment Form is a KDHE Form and is acceptable, a Physician Health Assessment Form is acceptable, and a School Health Assessment Form is acceptable for school-age children or youth. The Health Assessment Form used should be attached to the KDHE Medical Record Form (CCL. 029).

Child's Name _____ **Date of Birth** _____
First Last

Health history and medical information pertinent to routine child care and emergencies (describe, if any): <input type="checkbox"/> None	Do you see this child for regular health supervision: <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to food or medicine (describe, if any): <input type="checkbox"/> None	
List current medications (if any): <input type="checkbox"/> None	

Length/Height: _____ IN/CM %ILE _____		Weight: _____ LB/KG %ILE _____
Physical Examination	✓ If Normal	If Abnormal - Comments
Head/Ears/Eyes/Nose/Throat		
Teeth		
Cardio/Respiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurologic & Developmental		
Screening Tests	Screening Date	Note Here if Results are Pending or Abnormal
Lead		
Anemia (HGB/HCT)		
Urinalysis (UA)		
Hearing		
Vision		
Health Problems or Special Needs, Recommended Treatment/Medications/Special Care (Attach additional sheets if necessary) <input type="checkbox"/> None		
Signature of Licensed Physician or Nurse approved for Child Health Assessments	Date	
Print the Name of the Individual Signing Above	Phone Number	
Address	City	Zip Code



AUTHORIZATION FOR EMERGENCY MEDICAL CARE

Written permission for emergency medical treatment must be on file at the facility. Consult with the local emergency medical facility to be sure this form is acceptable. Reference K.A.R. 28-4-127(b)(1)(A). School Age Programs reference K.A.R. 28-4-582(e)(2).

Name of facility exactly as stated on the license.	License #
--	-----------

I authorize _____ (caregiver/staff) who is (are) representative(s) of the above-named facility to give consent for any and all necessary emergency medical care for my child or youth _____ (child's first and last name) while child or youth is in the facility's custody between _____ and _____.
MM/DD/YYYY MM/DD/YYYY

Is child covered by health insurance? Yes No

If yes, complete the following:

Health Insurance Policy Name _____ Policy Number _____
Medical Assistance Program _____ Card Number _____
Military Medical Care I.D. Number _____

If known, date of last Tetanus inoculation: _____
MM/DD/YYYY

List any known allergies or other information about the medical conditions of this child or youth pertinent in case of emergency:

Signature of Parent or Guardian	Date Signed
---------------------------------	-------------

Witness to Parent's or Guardian's signature if required by the local hospital or clinic.	Date Signed
--	-------------

Notarization of Parent's or Guardian's signature if required by local hospital or clinic.

State of Kansas County of _____
Signed or attested before me on _____ by _____ MM/DD/YYYY Name of Person
(Seal, if any.)
_____ Signature of notarial officer
_____ Title (and Rank)
My appointment expires: _____

The Medical Record/Assessment Form (Or Health Status History form for School Age Programs) and the authorization for Emergency Medical Care must be taken to the emergency room. Both forms must also be in a vehicle when the child or youth is transported by the facility.

CACFP Meal Benefit Income Eligibility (Child Care)

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

APPLY ONLINE:

Insert URL Here

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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 Household Members listed in STEP 1 here.

Child Income

How often? Weekly Bi-Weekly Monthly Bi-Monthly

B. All Adult 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 Adult Household Members (First and last)	Earnings from Work	How often?				Welfare/Child Support/Alimony	Pensions/Retirement/Social Security/SSI/VA Benefits	How often?			
		Weekly	Bi-Weekly	Monthly	2x Month			Weekly	Bi-Weekly	Monthly	2x Month
<input type="text"/>	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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<input type="text"/>	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="text"/>	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="text"/>	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Total Household Members (Children and Adults) Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or other Adult Household Member Check if no SSN

STEP 4 Contact information and adult signature. MAIL COMPLETED FORM TO YOUR SCHOOL AT:

"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."

<input type="text"/>	<input type="text"/>	<input type="text"/>
Print Name of Adult Signing the Form	Signature of Adult	Today's Date
<input type="text"/>	<input type="text"/>	<input type="text"/>
Address	City	State Zip Phone/Email

Source of Income for Children	
Sources of Child Income	Examples
Earnings from work	<ul style="list-style-type: none"> A child has a regular full or part-time job where they earn a salary or wages
Social Security - Disability Payments - Survivors Benefits	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> A friend or extended family member regularly gives a child spending money
Income from any other source	<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> Salary, wages, cash bonuses Net income from self-employment (farm or business) <p>If you are in the U.S. Military:</p> <ul style="list-style-type: none"> Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) Allowances for off-base housing, food, and clothing 	<ul style="list-style-type: none"> Unemployment benefits Workers compensation Supplemental Security Income (SSI) Cash assistance from State or local government Alimony payments Child support payments Veterans benefits Strike benefits 	<ul style="list-style-type: none"> 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?	Household size	Categorial Eligibility <input type="checkbox"/>	Eligibility																	
<input type="text"/>	<table border="1"> <tr> <td>Weekly</td> <td>Bi-Weekly</td> <td>Monthly</td> <td>2x Month</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>	Weekly	Bi-Weekly	Monthly	2x Month	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="checkbox"/>	<table border="1"> <tr> <td>Free</td> <td>Reduced</td> <td>Denied</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>	Free	Reduced	Denied	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Weekly	Bi-Weekly	Monthly	2x Month																		
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Free	Reduced	Denied																			
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																			
Determining Official's Signature	Date	Confirming Official's Signature	Date	Follow-up Official's Signature	Date																