

To complete your child's enrollment:

- **ALL** the paperwork in this folder must be filled out
- Schedule an appointment to return it
- Paperwork must be returned at least **ONE DAY** prior to your child starting fulltime or drop in childcare.

Call for Appointment to return paperwork - 449-5633

Also you must have:

- 1) An Up to date immunization record
- 2) Sponsor's signature in the areas indicated
- 3) A power of attorney if sponsor is deployed
- 4) * Sponsor's current LES
- 5) * Spouses current LES/pay stub/college schedule must show taking 12 credit hours to receive fulltime care. (Indicate if paid every 2 weeks, month, etc...)
- 6) Health assessment (physical) signed and stamped by the doctor & signed by parent **OR** an appointment slip from doctor or clinic office stating what date the appointment will be on.
- 7) A copy of the sponsor's dependency application (1751) NAV MC 10922 is required for all **single military**.
- 8) If your child has been identified with a special need then a Special Needs Evaluation Review Team (SNERT) will need to meet **prior to your child starting** to review your child's needs and assure his or her educational, physical or medical needs can be met.
A child with special needs may be identified as having:
Asthma, allergies, autism, developmental delays, behavioral issues, hearing, Orthopedic or visual impairment, mental, physical or emotional challenges, speech/language impairment or other health conditions included in the EFMP program.
- 9) * If form is highlighted, only fill in those areas

* needed for full time care only

For **each** full-time childcare space accepted, a \$25.00 non-refundable payment must be made to the program within 48 hours. The payment will be deducted from the first full payment. Failure to make this payment will result in a loss of the child care space.

Orientation Checklist

1. CYTP Guidelines

- MCO / SOP Series
- Parent Handbook – please read entire book
- Exceptional Family Member Program (EFMP) Enrollment required for any Special Needs
- Dependent Care Certificate (10922) required for Single military
- General Power of Attorney required to sign in place of the sponsor

2. CDC, SAC and Youth Activities Operations

- Registration Packet – Does your child have any allergies?
- Updated Shot Card and Annual Health Assessment required
- Asthma/Allergy Action Plan required
- Special Needs Evaluation Review Team (SNERT) required for special needs prior to start date
- Emergency Contact Numbers required from Two(2) local people other than parents
- Sick Child Procedure
- Disenrollment/Withdrawals taken on the 1st & 15th of each month only
- Late Accounts (\$6.00 a day up until 5 day then you will be disenrolled)
- Closing Dates listed on calendar and subject to change
- No outside food or toys brought into the facility – we substituted for food allergies
- Medication Forms and Regulations
- Photo ID required each day to pick up your child – no exceptions

3. Child Development Program

- CDC Accreditation - National Association for the Education of Young Children (NAEYC)
- SAC Accreditation – National Afterschool Association (NAA) and NAEYC
- Staff – Background Checks, Health Card, First Aid/CPR/Medication Certified
- Annual Training Requirements, Training Modules and Child Abuse Identification Training
- Lesson Plans and Themes – Age Appropriate Activities: Cognitive, Social/Emotional and Physical Skills
- Parent Teacher Conferences

USDA: Meals

1. Breakfast	0800-0830	SAC Breakfast	0730-0830
2. Lunch	1100-1130	SAC Lunch	1100-1200 (full daycare only)
3. Snack	1400-1430	SAC Snack	1500-1600

I state, by signing this Orientation Checklist I fully understand the policies & regulations of the Children, Youth and Teen Program & have read the parent handbook and agree to abide by the Center's policies & regulations.

Signature of Sponsor/Spouse

Date

Administrative Signature

**DEPARTMENT OF DEFENSE CHILD DEVELOPMENT PROGRAM
REQUEST FOR CARE RECORD**

PRIVACY ACT STATEMENT

AUTHORITY: PL 101-89 Sec. 1507; EO 9397.

ROUTINE USE(S): None.

PRINCIPAL PURPOSE(S): To collect applicant information for Child Development Programs and place applicants on waiting lists for program services. Information compiled from applications is also used to assist management determination of effectiveness of present and projection of future program requirements.

DISCLOSURE: Voluntary; however, failure to furnish requested information will result in an incomplete request for care record and possible loss of placement on Child Development Program waiting lists.

1. DATE OF REQUEST (YYYYMMDD)

2. EXPIRATION DATE (YYYYMMDD)

3. FAMILY INFORMATION

a. SPONSOR'S NAME (Last, First, Middle Initial)

b. SPOUSE'S NAME (Last, First, Middle Initial)

c. CHILD'S NAME (Last, First, Middle Initial)

d. CHILD'S DATE OF BIRTH (YYYYMMDD)

e. CHILD'S AGE

f. HOME ADDRESS (Street, City, State, Zip Code)

g. SPONSOR'S BRANCH OF SERVICE

h. DUTY ORGANIZATION

i. HOME TELEPHONE NUMBER (Include Area Code)

j. DUTY TELEPHONE NUMBER (Include Area Code)

k. SIBLING CARE (Complete a separate form and list name and date of birth for each child requiring care)

(1) NAME (Last, First, Middle Initial)

(2) DATE OF BIRTH (YYYYMMDD)

(1) NAME (Last, First, Middle Initial)

(2) DATE OF BIRTH (YYYYMMDD)

4. PROGRAM(S) DESIRED (X as applicable)

5. AGE GROUP (X one)

a. FULL-DAY CARE

e. FAMILY DAY CARE (FDC)

a. INFANTS (0 - 12 months)

b. PART-DAY CARE

f. PART-DAY ENRICHMENT

b. TODDLERS (13 - 35 months)

c. SCHOOL-AGE

g. DAY CAMP

c. PRESCHOOL (3 - 5 years)

d. SPECIAL NEEDS

d. SCHOOL AGE (5+ years)

6. SPONSOR STATUS (X one)

a. SINGLE MILITARY

e. SINGLE DOD CIVILIAN

i. MILITARY/UNEMPLOYED SPOUSE

b. DUAL MILITARY

f. RETIRED MILITARY

j. MILITARY/OTHER THAN DOD SPOUSE

c. MILITARY/DOD SPOUSE

g. MILITARY RESERVE

k. OTHER (Specify)

d. DUAL DOD CIVILIANS

h. NATIONAL GUARD

7. PRESENT CHILD CARE ARRANGEMENTS (X as applicable)

a. FDC ON-INSTALLATION

d. CIVILIAN CDC

g. IN-HOME CARE

b. FDC OFF-INSTALLATION

e. MILITARY ALTERNATE CARE

h. NO PRESENT CARE

c. OTHER MILITARY CHILD DEVELOPMENT CENTER (CDC)

f. NON-MILITARY ALTERNATE CARE

i. OTHER (Specify)

8. GENERAL INFORMATION (X and complete as applicable)

YES	NO	a. IF CHILD IS NOT PRESENTLY IN CARE, IS EMPLOYMENT OF SPOUSE AWAITED? (If Yes, estimate average annual income lost)	YES	NO	c. IS CHILD ON OTHER MILITARY WAITING LIST? (If Yes, name installation)

		b. HAS CHILD BEEN IDENTIFIED FOR SPECIAL NEEDS CARE?	d. CURRENT COST OF CARE PER WEEK (If child is currently in care)
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9. UPDATE REQUIRED PER INSTRUCTIONS (For Office Use Only)

	(1)	(2)	(3)	(4)	(5)
a. DATE CALLED (YYYYMMDD)					
b. DECLINED/ PLACED					
c. COMMENTS/ INITIALS					
d. PLACEMENT TIME (In months)					

**CHILDREN, YOUTH & TEEN PROGRAMS (CYTP)
CHILD HEALTH ASSESSMENT**

NAME OF SPONSOR & SPOUSE (Last, First, MI)	TELEPHONE (Home)	TELEPHONE (Duty)
NAME OF MEDICAL TREATMENT FACILITY/ PHYSICIAN	ADDRESS (Include ZIP Code)	TELEPHONE
CHILD HEALTH INFORMATION		
NAME OF CHILD	BIRTHDATE	SEX HGT WGT
HAS CHILD BEEN UNDER REGULAR SUPERVISION OF A PHYSICIAN? (If yes, explain circumstances and current status) YES NO		
HAS CHILD BEEN SCREENED FOR ENROLLMENT IN EXCEPTIONAL FAMILY MEMBER PROGRAM? YES NO		
COPY OF IMMUNIZATION RECORD SUBMITTED? YES NO		
DISEASES AND ILLNESSES (CHECK YES OR NO)		
CHICKEN POX YES NO RUBELLA YES NO TEN-DAY MEASLES YES NO		
MUMPS YES NO POLIOMYELITIS YES NO SCARLET FEVER YES NO		
RHEUMATIC FEVER YES NO		
OTHER (List)		
CHRONIC ILLNESS AND CONDITIONS (CHECK YES OR NO)		
VISIONS PROBLEMS YES NO ASTHMA YES NO DIABETES YES NO		
ORTHOPEDIC PROBLEMS YES NO AUDITORY PROBLEMS YES NO		
SEIZURE DISORDER YES NO		
OTHER (List)		
ALLERGIES (List)		
COMMENT / INDICATE FREQUENCY		
COLDS		
EAR ACHES		
STOMACH ACHES		
HEADACHES		
DIARRHEA		
CONSTIPATION		

COMMENT / INDICATE FREQUENCY

BED WETTING

SLEEP DIFFICULTIES

POOR EATING HABITS

TANTRUMS

EXCESSIVE ACTIVITY

DESCRIPTION OF SERIOUS CHRONIC ILLNESS / CONDITIONS

ILLNESS / CONDITIONS

DESCRIPTIONS

ON-GOING MEDICATION

TYPE

DOSAGE

FREQUENCY

CDP ADMINISTERED

SPECIAL MEDICAL CONSIDERATIONS

DESCRIBE ANY SPECIAL PROGRAM NEEDS, CONSIDERATIONS, OR RESTRICTIONS WHICH THE CHILD REQUIRES, IN ORDER TO PARTICIPATE IN CDP.

MEDICAL STATEMENT

The above named child has been given a routine examination (per age requirements) and is free of infectious or contagious diseases, and is considered to be capable of participating in Child Development Program with the exception listed above.

SIGNATURE OF SPONSOR / SPOUSE

DATE

SIGNATURE OF PHYSICIAN & MEDICAL STAMP

DATE

Please circle the program your child is enrolled in:

Full-Time Part-Day Drop-In Family Child Care School Age Care

HEALTH ASSESSMENT DATE: _____

**** I will furnish the CYTP a Health Assessment within 30 Days Initials _____**

CHILD'S MEDICAL HISTORY

Special Needs: _____

Allergies (medication, food, etc.): _____

Current Medication: _____

Is your child under the care of a doctor _____ Yes _____ No

If yes, what for? _____

AUTHORIZATION TO CONSENT TO MEDICAL CARE

I, _____ parent/guardian of _____

give consent for an authorized CYTP representative or the FCC provider, _____ to take my child for care, medical or dental, in an emergency situation where the child's condition represents a serious or imminent threat to his/her life, health or well being. I understand that a conscientious effort will be made to notify me prior to such action. Emergency medical personnel will transport to the Naval Hospital Camp Lejeune when necessary. I also authorize appropriate medical personnel to administer, in my absence, medical treatment necessary to maintain life to my above named child in the event of serious illness or injury.

Signature: _____

MEDICATION RELEASE OF LIABILITY

I hereby release and forever discharge the Children, Youth and Teen Program and its employees or agents from any and all liability arising in law or equity as a result of administering any medication or treatment authorized above. This wavier and release of liability includes, but is not limited to, claims, actions, expenses, damages, injury, death, loss or damage to material and/or equipment supplied by the parent(s)/guardian(s), in any way relating to the administration of medication or treatment.

Parent/Guardian Signature _____

Please indicate below if you authorize your child to participate in the following:

Child can be photographed or videotaped while participating in program activities
(Photos may be used for advertisement for Children, Youth & Teen Programs)

Yes No

Field trips/go on walks/buggy rides (infants)

Yes No

Family Child Care Only: In addition to above items

Ride in FCC Provider's Car

Yes No

Go to Park/Visit Neighbors/Play on Sidewalk

Yes No

For School Age Children Only:

INTERNET RELEASE OF LIABILITY

The Youth and Teen Programs have access to computers and the Internet. In order for your Youth or Teen to use the computers and the Internet the parent must sign below. The Youth and Teen programs will monitor and block accesses to inappropriate sites, however the parents need to understand that access may be inappropriately obtained.

I give permission for my child _____ to be involved in the usage of the computer and Internet.

Parent/Guardian Signature _____

TRANSPORTATION RELEASE OF LIABILITY

I, the parent / guardian of _____, voluntarily accept free transportation for my child listed above from MCCS New River Children, Youth and Teen School Age Childcare Program. In exchange for the identified free transportation, I hereby release the United States Government, including all its subdivisions, officers, military personnel, employees and agents from all liability for any injuries or death that may result to my child from this transportation, whether caused by negligence or otherwise. I understand that in transporting my child, the United States Government is not acting as a common carrier for hire and does not bear the liabilities attaching to that status. I incur no obligation towards the United States Government except as imposed by this release. I agree that this release not only binds me, but also my family, heirs, assigns administrators and executors.

Parent/Guardian Signature _____

MCAS NEW RIVER CHILDREN YOUTH AND TEEN PROGRAMS
SPECIAL NEEDS SCREENING FORM

Purpose: To provide child and family program eligibility and background information; to assist with child's placement and obtain sponsor consent for access to emergency medical care; data required by EFMP. Policies shall be implemented to ensure that appropriate services are provided for children, youth and teens with special needs. Such policies shall meet the requirement of the Rehabilitation Acts and the Department of Defense Directive 1020.1, Non Discrimination on the Basis of Handicap in Programs and Activities Assisted or Conducted by the Department of Defense.

Routine Uses: This information will be shared with members of the Special Needs Evaluation Review Team (SNERT) to assist with making an informed decision about your child's placement. Information is used for program admission to ensure staff training is pertinent to the child's needs. Information is furnished for the attending physician when it is necessary for a child to be taken to a medical facility by someone other than the parent.

Disclosures: Disclosure of information is voluntary; however, if information is not provided, individuals may not be allowed to participate in Children Youth and Teen Programs. Please note any medication your child may take, or has taken consistently in the last six months.

Child's Name _____ DOB _____ Program _____

Sponsor's Name _____

Exceptional Family Member Program (EFMP) Enrolled (circle) YES/NO

PLEASE CHECK ALL THAT APPLY IF YOUR CHILD HAS BEEN DIAGNOSED WITH ANY OF THE FOLLOWING MEDICAL OR DEVELOPMENTAL CONDITIONS:

___ Allergy (Food or Insect) explain reaction:

- | | |
|---|--|
| ___ Allergy Seasonal | ___ Epilepsy/Seizures |
| ___ Apnea Monitor | ___ Genetic Disorders/Congenital Anomalies |
| ___ ADD or ADHD | ___ Hearing Impaired |
| ___ Asthma or (RAD) | ___ Heart conditions (congenital or acquired) |
| ___ Autism/Pervasive Developmental Disorder | ___ Hydrocephalus/Macrocephaly |
| ___ Behavior Concerns (ODD, etc) | ___ Immune Deficiency |
| ___ Brittle Bones | ___ Inflammatory Bowel Disease (Crohns, UC) |
| ___ Cancer | ___ Psychological Cond (Depression, OCD, etc) |
| ___ Cerebral Palsy/Loss of Mobility | ___ Orthopedic Impairment |
| ___ Cleft Lip and/or Palate (Not repaired) | ___ Premature Infant (<35 weeks) |
| ___ Cystic Fibrosis | ___ Spina Bifida |
| ___ Developmental delays | ___ Speech delay |
| ___ Down Syndrome | ___ Visually Impaired (not corrected by glasses) |
| ___ Equipment needs (g-tube, colostomy,
O2, tracheotomy, wheelchair, etc.) | ___ Other _____ |

Routine Medication(s) _____

Required Special Care or Services(s) _____

___ My Child has **NO** special needs or diagnosed condition(s)

Parent Signature

Date

Administrative Signature

**CHILDREN, YOUTH AND TEEN PROGRAM PAYMENT POLICY
MARINE CORPS AIR STATION, NEW RIVER**

Once this payment policy is signed, the sponsor's child/ren is/are considered enrolled in the Children, Youth and Teen Program (CYTP) and the sponsor is responsible for adhering to the guidelines outlined in this policy. For each full-time childcare space that is accepted, a \$25.00 non-refundable payment must be made to the program within 48 hours. This payment will be deducted from the first full payment. Failure to make this payment will result in a loss of the child care space.

1. The bimonthly rates for all programs are based on total family income. Income categories and fees are based on guidelines established by the Department of Defense. Fees are evaluated annually and all CYTP can be impacted in order to be in compliance with the Military Child Care Fee Policy.
 2. Fees are **payable in advance** of childcare received. Fees for fulltime enrolled children are due on the 1st and the 15th of each month, coinciding with military paydays. In the event that the 1st or 15th falls on a weekend or holiday, fees will be due on the first day the center is open following the weekend or holiday. Families will be granted a one-day grace period if fees are not paid on the first or fifteenth. However, if fees are not paid following the grace period, a late fee of \$6.00 per day will be assessed until the fee is paid in full. However, if five days of late fees are charged to your account and you have not made arrangements with the Director/Administrator to bring your account up to date, the program may terminate your contract. If you are on leave, or your child is out due to illness, please make arrangements to ensure your fees are kept current to avoid any additional charges. Please remember, fees are due whether your child is in attendance or not.
 3. The cash registers close daily at 1730. If you are paying with cash or credit card, payments must be made by 1730 in order to receive credit on your account for that day. Payments made by check can be placed in the payment drop box and will be credited for the day that they were placed in the drop box.
 4. **Fees will not be prorated for any reason. There is no discount for families with more than one child enrolled within the program.**
 5. Our programs are closed on all federal holidays and some additional days approved by the command. A calendar is provided but is subject to change.
 6. Notices of written disenrollment will only be accepted on the first of the month for the last day of attendance to be on the fourteenth and on the fifteenth of the month for the last day of attendance to be the thirtieth/thirty-first. If proper notice is not given, or arrangements are not made, you will be charged through the next payment period whether your child is in attendance or not.
 7. All programs close at 1800. If children are left in any program after closing time, a late fee will be charged. Additionally, if a child is left at one of the programs for more than thirty minutes after closing, the Provost's Marshal's Office (PMO) will be contacted for assistance in locating parents.
- ** Late fees will be charged for full time & hourly care children and are due prior to dropping off your child/ren the following business day.
- \$6.00 per child for any portion of the first fifteen minutes and \$1.00 per child for each additional minute after the first fifteen minutes
Continued late pick-ups or failure to pay late fees may result in a loss of childcare privileges.
8. Hourly childcare will be offered from 0800-1700 Monday – Friday for the CDC. Fees will be paid at drop off the day services are rendered for the time reserved. Patrons are required to pay for all hours reserved even when dropping off after reserved start time and if the child/ren is/are picked up early. The minimum required reservation time is one (1) hour. Reservations may be cancelled 24 hours in advance. Failure to cancel reservation(s) 24 hours in advance will result in paying for time that space was reserved, even if the child is sick unless a doctor's note is provided. Patrons may not make additional reservations until fees for prior reservations or late fees have been paid in full. For 24-hour cancellation on weekends or center closings call (910) 449-6713 for the CDC and (910)449-6711 for the Youth Center.
 9. Children enrolled for full time childcare will be granted one-week vacation during the calendar year. (Child Care fees will be waived for this week) It may be taken any time during the year after being enrolled in the program for **three months**. It must be taken over 5 consecutive work days. Fees will not be prorated for holidays, early closure days, training day closures, base closures, additional vacation days, illness or emergencies.
 10. Children enrolled in both the Before and After Care Program for School Age Care (SAC) will be granted one week vacation during the school calendar year which can be taken after being enrolled for three months.
 - SAC Half Day Care does not apply to children enrolled within just the before school or just the after school care programs, additional drop in rates of \$3.00 an hour per child will be charged for any other hours needed other than the normal hours for each program.
 - There is a separate fee scale for fulltime SAC children during Winter Break and Spring Break, children enrolled within either just the before school program or just the after school program will be charged their regular bi-monthly payment and get credited for 3 hours a day for days requiring full day care and also charged the \$3.00 an hour drop in rate for any additional hours they will need for each of the days requiring the full care. Children who will not be utilizing the Winter Break or Spring Break option to have fulltime care will be required to pay their regular bi-monthly fees which will not be prorated.

I HAVE READ AND UNDERSTAND THE ABOVE PAYMENT AND WITHDRAWAL POLICY AS OUTLINED FOR CYTP. I AGREE TO ABIDE BY THESE POLICIES AND REGULATIONS AND ACKNOWLEDGE THAT I HAVE RECEIVED A CALENDAR WITH CLOSING DATES.

Printed Name of Sponsor: _____

Sponsor's Signature: _____ Date: _____

STATEMENT OF UNDERSTANDING
CHILD AND ADULT FOOD PROGRAM (CACFP)

THE CHILDREN, YOUTH AND TEEN PROGRAM PARTICIPATES IN THE UNITED STATES DEPARTMENT OF AGRICULTURE SPONSORED CHILD AND ADULT CARE FOOD PROGRAM (CACFP) TO PROVIDE NUTRITIONALLY BALANCED MEALS AND SNACKS TO THE CHILDREN ENROLLED. ACCORDINGLY, THE FOLLOWING CACFP REGULATION MUST BE ADHERED TO:

1. NO OUTSIDE FOOD MAY BE BROUGHT INTO THE CHILD DEVELOPMENT CENTER OR SCHOOL AGE CARE PROGRAM, FOR MEALS, WITH THE EXCEPTION OF INFANT FORMULA OR FOOD REQUIRED TO MEET A SPECIAL DIETARY NEED THAT CANNOT BE MET AT THE FACILITY.

2. CHILD NUTRITION REGULARION CFR 226.20(H) STATES:
“SUBSTITUTIONS MAY BE MADE IN FOOD IF INDIVIDUAL PARTICIPANTS ARE UNABLE, BECAUSE OF MEDICAL OR OTHER SPECIAL DIETARY NEEDS, TO CONSUME SUCH FOODS. SUBSTITUTIONS BECAUSE OF MEDICAL NEEDS SHALL BE MADE ONLY WHEN SUPPORTED BY A STATEMENT FROM A RECOGNIZED MEDICAL AUTHORITY, WHICH INCLUDES RECOMMENDED ALTERNATE FOODS.”

A) **FOOD ALLERGIES:** PARENTS ARE REQUESTED TO PROVIDE A DOCTOR’S STATEMENT DOCUMENTING ANY FOOD ALLERGY (IES) AND RECOMMENDING SUBSTITUTIONS FOR THOSE FOODS. UPON RECEIPT OF THIS INFORMATION, THE CENTER MAY PROVIDE THE RECOMMENDED ALTERNATE FOOD ITEM(S) FOR THE CHILD.

B) **RELIGIOUS BELIEFS:** PARENTS ARE ASKED TO PROVIDE A DOCTOR’S STATEMENT SPECIFYING, BASED ON RELIGIOUS BELIEFS, THE FOOD OR FOOD COMPONENTS FOR WHICH AN ALTERNATE ITEM IS REQUESTED. ONCE THIS INFORMATION IS RECEIVED, IT WILL BE SENT TO THE NORTH CAROLINA DEPARTMENT OF PUBLIC HEALTH CHILD NUTRITION SERVICES SECTION, FOR APPROVAL. ONCE APPROVAL IS GRANTED, SUBSTITUTIONS CAN BE MADE.

I UNDERSTAND AND AGREE TO THE ABOVE GUIDELINES FOR THE CACFP PROGRAM.

CHILD’S NAME

PROGRAM: Child Development Center
 School Age Care Program

PARENT SIGNATURE

DATE

ACTION PLAN

(To be completed by pediatric health professional and signed by parent)

Date: _____

Child's Name: _____

Medical conditions of Concern:

Signs or symptoms to watch for: Treatment or Modification of Environment

Note: When possible, please reduce or eliminate medication administration in _____

Medications (if applicable)			
Dosage(s)			
Time(s) of Administration			
Dates of Administration			
Possible Side Effects			

Pediatric Health Professional Signature

Phone

I hereby give permission for the childcare provider or FCC provider to administer medication as prescribed above. I also give permission for the childcare provider or FCC provider to contact the prescribing pediatric health professional regarding the administration of this medication if there are problems or questions.

Print Parent/Guardian Name

Parent/Guardian Signature

If the recommended steps above do not help my child, please call me immediately. If you cannot reach me in a timely manner, please activate the emergency medical services.

Parent/Guardian Contact Info:

Home phone

Work Phone

Cell Phone

Pager

As the Parent/guardian, I will, in writing, keep the program informed of any change to my phone numbers.

Parent/Guardian Signature: _____

Institution Name: _____

Agreement Number: _____

Facility/Provider Name: _____

Child and Adult Care Food Program (CACFP) Participant Enrollment Form

Dear Parent/Guardian,

Your day care facility participates in the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). The enrolled participant will receive nutritious meals and snacks at no cost to you. CACFP needs verification of enrollment for each participant in this facility. Please fill out the parent/guardian section of this form, sign it and return it to the above facility/provider. Provide information for one participant per section. **(In order for the institution to receive reimbursement for meals served/claimed, this form must be completed for each enrolled participant annually.)**

Participant's Name: _____ Date of Birth: _____ Age: _____

Sex: Male Female

Date participant enrolled in facility: _____

Food Allergies: Yes No If "yes", specify: _____

(If the participant cannot be served the CACFP Meal Pattern, a statement from participant's Health Care Provider must be provided.)

Check Days of Normal Care at facility: Sunday Monday Tuesday Wednesday Thursday Friday Saturday

Check Meals normally eaten at facility: Breakfast AM Snack Lunch PM Snack Supper Evening Snack

Please list the normal times of arrival and departure (**check am or pm**): **Arrive:** _____ am pm. **Depart:** _____ am pm

If participant is an infant (0-11months), please complete this box. Check all applicable choice(s) below:

This institution/facility offers _____ formula for infants through the CACFP. It is your choice
(To be completed by facility/provider)
whether or not to use this formula based on your infant's needs. Baby foods provided by the institution/facility must be in compliance with the infant meal pattern as required by 7CFR 226.20.

- I will use the formula offered by this facility. I give permission for the formula to be mixed and/or bottles to be prepared for my infant by this facility's staff.
- I will not use the formula offered by this facility.
If not, which formula will you send for your infant? _____
If the formula you provide is a special formula, a medical statement must be submitted.
- I will provide breastmilk for my infant.
- My infant is four (4) months old or older and is developmentally ready for baby foods. I want the institution/facility to provide the following baby food(s) for my infant, which is/are allowed under 7CFR 226.20 (b)(2)(3)(4). _____

Note to parents who are getting formula through the WIC Program: Your baby is eligible to get formula from this child care institution/facility as well as from the WIC Program. It is your decision which formula you want your baby to use when she/he is at child care. If you find you are getting more formula than your baby needs, you may wish to talk with your WIC nutritionist or your child care provider.

Parent/Guardian Signature: _____

Date: _____

Print Name: _____

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

Home Telephone Number: () _____

Work Telephone Number: () _____ Check Work Shift: 1st 2nd 3rd Other (Specify) _____

For Facility/Provider Use Only:

Signature of Facility Representative/Provider: _____ Date: _____

Date the participant withdrew: _____

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 Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

**North Carolina
Department of Health and Human Services
Women's and Children's Health
CHILD AND ADULT CARE FOOD PROGRAM
CHILD ELIGIBILITY APPLICATION**

1. PRINT THE PARTICIPANT'S NAME AND DATE OF BIRTH:

NAME OF INSTITUTION: _____

AGREEMENT NUMBER: _____

First Name Last Name Date of Birth

FACILITY NAME: _____

First Name Last Name Date of Birth

2. SNAP, TANF or FDPIR: If the household currently receives SNAP, TANF or FDPIR benefits give the case number. Yes, we receive SNAP, TANF or FDPIR benefits. Case number is: **SNAP #** _____
TANF # _____ **FDPIR #** _____

If yes, and you have provided the case number; **DO NOT complete #3 and #4. Complete #5 (voluntary) and #6.** If a child is a member of a SNAP or FDPIR household or TANF assistance unit, the child is automatically eligible to receive free Program meal benefits, subject to the completion of the application.

3. Is this a Foster Child? Yes No. Households with foster and non-foster children may choose to include the foster child as a household member, as well as any personal income earned by the foster child, on the same household application that includes their non-foster children.

Is this a homeless child or a child evacuated from Japan or Bahrain? Yes No. Certification from the agency that assisted with the evacuation or is providing shelter is required.

4. HOUSEHOLD MEMBERS MONTHLY INCOME: List all others living in your household, **DO NOT** include participant listed above. List all gross income (**before deductions**) received last month. If you did not give a SNAP, TANF or FDPIR case number or if this is not a foster child, you must complete the income information.

Names of all Other Household Members	Monthly Wages Salaries	Monthly Social Security Earnings	Monthly Public Assistance/ Child Support Earnings	Monthly Retirement Pensions Earnings	Monthly Other Earnings
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$

5. ETHNIC IDENTITY: (Please check one).

Hispanic or Latino Not Hispanic or Latino

RACE OF PARTICIPANT: (Please check one or more).

White Black or African American American Indian or Alaskan Native Asian
 Native Hawaiian or Other Pacific Islander

6. SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER: I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds; that Program officials may verify the information on the application and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal criminal laws.

Signature of Adult Household Member (Required) _____

Date: _____

Last Four Digits of Social Security Number ((Required for households qualifying by income)

Printed Name _____

Home Telephone # _____

Work Telephone # _____

Address _____

City _____

Zip Code _____

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 your child 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 last four digits of the social security number is not required when you apply on behalf of a foster child or you list a SNAP, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child 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 your child is eligible for free or reduced price meals and for administration and enforcement of the Program. If a child is a Head Start participant, the child is automatically eligible to receive free Program meal benefits, subject to submission by Head Start officials of a Head Start statement of income eligibility or income eligibility documentation.

For Institution To be classified and completed by institution/sponsor

TOTAL HOUSEHOLD SIZE _____ TOTAL HOUSEHOLD MONTHLY INCOME \$ _____

Approved: Free Reduced Denied

Reason for denial: Income too high Incomplete application Other

Withdrew on (Date): _____

For state use only:

Verified by: _____ Date: _____

Verified classification: Free Reduced Denied

Reason for change in classification: _____

Signature of Eligibility Official _____
CAC 11 (6/11) Nutrition Services

Date _____

CACFP ELIGIBILITY APPLICATION INSTRUCTIONS

Please complete the Child and Adult Care Food Program Eligibility Applications using the instructions below. Sign the statement and return it to your child care center.

PART 1-PARTICIPANT'S INFORMATION: Complete this part.

Print the name(s) of the child enrolled in the center.

PART 2-HOUSEHOLD GETTING SNAP, TANF, OR FDPIR BENEFITS: Complete this PART and PART 6.

- (1) List your current SNAP, TANF, or FDPIR case identification number.
- (2) An adult household member must sign the statement in PART 6.

PART 3-FOSTER or HOMELESS CHILD (Including children evacuated from Japan and Bahrain)

- (1) Indicate if child is a Foster Child or is homeless. Households with foster and non-foster children may choose to include the foster child as a household member, as well as any personal income earned by the foster child, on the same household application that includes their non-foster children. Additionally, when a host family applies for free and reduced price meals for their own children, the host family may include the homeless family as household members if the host family provides financial support to the homeless family. In such cases, the host family must also include any income received by the homeless family.
- (2) An Adult household Member must sign the statement in PART 6.

PART 4- HOUSEHOLD INCOME: Complete this PART and PART 6

- (1) List the names of household members.
- (2) Write the amount of income (the amount before taxes or anything else is taken out), the frequency of income (i.e. weekly, every two weeks, twice a month, or monthly) received **last month** for each household member and where it came from, such as earnings, welfare, pensions and other income (refer to examples below for types of income to report). If any amount last month was less than usual, write the person's usual income.
- (3) An adult household member must sign this income eligibility statement and give the last four digits of his/her social security number in PART 6.

PART 5-RACIAL/ETHNIC IDENTITY: Complete the Ethnic/Racial identity question.

PART 6-SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER: All households complete this PART.

- (1) All eligibility statements must have this signature of an adult household member;
- (2) The adult household member who signs the statement must include the last four digits of his/her social security number. If he/she does not have a social security number, write "none". If you listed a SNAP, TANF, or FDIR number a social security number is not needed.

INCOME TO REPORT

Earnings from Employment

Wage/salaries/tips
Strike benefits

Unemployment compensation
Worker's compensation
Net income from self-owned
business or farm

Welfare/Child Support/Alimony

Public assistance payments
Welfare payments
Alimony/Child support payments

Pensions/Retirement/Social Security

Pensions
Supplemental security income
Retirement income
Veteran's payments
Social security

Military Households

All cash income, including military housing/uniform allowances. Does not include "in-kind" benefits NOT paid in cash (base housing, clothing, food, medical care, etc.)

Other Income

Disability benefits
Cash withdrawn from savings
Interest/dividends
Income from estates/trusts/
investments

Regular contributions from
persons not living in the
household
Net royalties/annuities/
net rental income
Any other income

All programs of the United States Department of Agriculture are available to everyone with out regard to race, color, sex, national origin, age or disability.

**PARENT GUARDIAN/HOUSEHOLD LETTER FOR NON-PRICING INSTITUTIONS
CHILD AND ADULT CARE FOOD PROGRAM**

Dear Parent or Guardian,

Please help us comply with the federal requirement mandating the annual submission of Program Eligibility Application (CAC 11). This application will be used only for eligibility determination, placed in our files and treated as confidential information. In order for participants and the day care center to be considered eligible for program benefits, an adult household member must complete the Program Eligibility Application for each participant enrolled in the center as soon as possible, sign, date and return it to the day care center. Completion of the application is not mandatory unless you wish to be considered for eligibility as a free or reduced price participant.

If you currently receive SNAP, Temporary Aid to Needy Families (TANF) or Food Distribution Program on Indian Reservations (FDPIR), you are not required to list household income. You may give your SNAP, TANF or FDPIR case number, sign, date and return the application. If a child is a member of a SNAP or FDPIR household or is a TANF recipient, the child is automatically eligible to receive free Program meal benefits, subject to completion of the application.

You should also note that if you have a foster child the day care center is eligible for program benefits for the foster child regardless of the income of your household. Households with foster and non-foster children may choose to include the foster child as a household member, as well as any personal income earned by the foster child, on the same household application that includes their non-foster children. Please contact the institution for further instructions.

You should list the name of everyone who lives in your household, including all children, parents, grandparents and other relatives. The Department of Agriculture defines a household as a group of related or unrelated individuals (not residents of an institution or boarding house) who are living as one economic unit (i.e. sharing living expenses).

The income which you report **must** be the total gross income, before deductions, received by all members of your household last month (i.e. wages, welfare or retirement etc). Military benefits received in cash, such as housing allowance for military households living off base and food or clothing allowance **must** be considered as income. If you have a household member whose last month's income was higher or lower than usual, list that person's expected average monthly income.

**EFFECTIVE JULY 1, 2011 - JUNE 30, 2012
REDUCED GUIDELINES**

HOUSEHOLD SIZE	YEARLY	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY
1	20,147	1,679	840	775	388
2	27,214	2,268	1,134	1,047	524
3	34,281	2,857	1,429	1,319	660
4	41,348	3,446	1,723	1,591	796
5	48,415	4,035	2,018	1,863	932
6	55,482	4,624	2,312	2,134	1,067
7	62,549	5,213	2,607	2,406	1,203
8	69,616	5,802	2,901	2,678	1,339
For each Household member add:	+7,067	+589	+295	+272	+136

You may submit a program eligibility application any time during the fiscal year. Participants having family members who become unemployed are eligible for free or reduced-price meals during the period of unemployment, provided that the loss of income causes the family's income during the period of unemployment to be within the eligibility standards for those meals.

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 (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.