

Child's Name: _____ Enrollment Date: _____

Date Complete: _____ FCC Provider: _____

The following items must be complete before file is ready to be taken to the FCC provider. Mark YES if they have it.

The FCC Director or Administrative Representative has authority to sign off on this file.

1. Request for Care Form: _____
2. Enrollment form with Emergency Contacts: _____
3. Medical History/Medical Consent: _____
4. Special Needs Screening: _____
5. Photography/Field Trip/Medication Release: _____
6. CACFP Eligibility Application: _____
7. CACFP Enrollment Form: _____
8. Immunization card (copy of shot card): _____
9. Health Assessment (physical): _____
10. Medical Action Plan (if applicable): _____
11. Power of Attorney (if applicable): _____
12. Family Care Plan (for single/dual military): _____
13. Hold Harmless Agreement form (**NOTARIZED**): _____
14. Back to Sleep Policy for infants: _____
15. Monetary policy: _____
16. Parent-Child Share Sheet: _____

I state, by signing this that I fully understand each form that was presented to me in this package. I have read the Parent handbook and agree to abide by the policies and regulations set forth in it. I am also aware that by enrolling my child with this FCC provider that I am **not enrolled** in the Child Development Center or School-Age Program for drop in care. If I have any questions or concerns, I will contact the FCC Director or Resource and Referral Specialist.

Parent/Guardian Signature

Date

FCC Director/Resource & Referral Specialist

Date

**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)
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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)		

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

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: _____

HOLD HARMLESS AGREEMENT FORM

KNOW ALL MEN BE THESE PRESENT, that, in consideration of the use by and for my child (ren) _____

Of government quarters located at _____

Presently assigned to _____

A person authorized to use said government quarters as a private family childcare facility, the sufficiency of said consideration being acknowledged, I hereby agree to HOLD HARMLESS the GOVERNMENT OF THE UNITED STATES OF AMERICA, the department of defense, the Department of the Navy, the United States Marine Corps, the Marine Corps Child Development Centers, Family Service Center, MCAS, New River and any departments, instrumentalities, agencies, officers, agents and employees from any and all claims, demands, damage, actions, causes of action or suits of any nature or kind whatsoever which may exist now or in the future against the UNITED STATES OF AMERICA, in relation to the use of said government quarters as a private family child care facility and FURTHER, I understand and hereby acknowledge that the family child care services specified herein are a private independent enterprise undertaken

by _____

And are in no way endorsed or supported by any foregoing government entities.

Sponsor's

Signature and Date

State of _____

County of _____

On this the _____ day of _____ 20____ before me personally came _____

To me known to be the individual described in and who executed the forgoing instrument, and he/she acknowledged that he/she executed the same.

Notary Public _____

My Commission Expire _____

MONETARY POLICY

In the event of a monetary dispute between a Family Childcare (FCC) Provider, and a parent, either party may contact the Family Childcare Director, and request that he, or she, mediate the dispute. If the FCC Director is unable to help the parties resolve the issue, the parents command may be contacted with the hope that the dispute can be resolved at the lowest possible level. If this is unsuccessful, either party remains free to take whatever action they deem necessary, including litigation.

I have read and understood the above policy statement.

Parent's Name	Signature	Date

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.

**CACFP INCOME ELIGIBILITY
CHILDREN ENROLLED IN FAMILY DAY CARE HOMES**

PART I

Child's Name: Last _____ First _____ M.I. _____ Date of Birth _____

Child's Name: Last _____ First _____ M.I. _____ Date of Birth _____

Provider's Name: _____

PART 2A - HOUSEHOLDS NOW GETTING SNAP, TANF/WORK FIRST, FDPIR, NATIONAL SCHOOL LUNCH OR WIC BENEFITS: Complete this part and sign the statement in PART 3 - DO NOT complete PART 2B. If a child or a child's parent is participating in or subsidized under a Federally or State supported child care or other benefit program with an income eligibility limit that does not exceed the eligibility standard for free or reduced price meals, meals served to the child are automatically eligible for tier I reimbursement, subject to the completion of the application.

SNAP case #: _____ WIC#: _____
 TANF/Work First identification #: _____ Receives Free/Reduced Priced School Lunch (NSLP) (Check if applies)
 FDPIR identification #: _____ Receives Free/Reduced Priced School Breakfast (SBP) (Check if applies)
(Food Distribution Program on Indian Reservations)
 Federally funded Head Start Program (Check if applies)

PART 2B - ALL OTHER HOUSEHOLD MEMBERS: If you did not complete PART 2A, complete this PART and PART 3.

NAMES		CURRENT INCOME/FREQUENCY - (Last Month)		
Names of All Household Members	Earnings from Work (Before Deductions) Job 1	Welfare, Child Support, Alimony	Payments from Pensions, Retirement, Social Security	Earnings from Job 2 or any Other Income

PART 2C - Complete this PART and PART 3. If this is a foster child check here (). Foster children are categorically eligible for free and reduced-price meals regardless of household income. 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.

PART 3 - SIGNATURE AND LAST FOUR DIGITS OF THE SOCIAL SECURITY NUMBER: An adult household member must sign the statement before it can be approved. 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: _____ Last Four Digits of Social Security Number: _____
(Required) (Required (last 4 digits) for households qualifying by income)

Printed name of Adult: _____ Date Signed: _____

Home Address _____ Zip Code _____ Home Telephone _____ Work Telephone _____

PART 4 - 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

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 Sponsoring Organization Use Only:

MONTHLY INCOME CONVERSION: WEEKLY X 4.33 EVERY 2 WEEKS X 2.15 TWICE A MONTH X 2

Total family income: _____ Family size: _____

Tier I _____ Eligible: _____

Tier II _____ Not Eligible: _____

Determining Official Signature: _____ Date: _____

For state use only:	
Verified by: _____	Date: _____
Verified classification: <input type="checkbox"/> Free <input type="checkbox"/> Reduced <input type="checkbox"/>	
Denied	
Reason for change in classification: _____	

**CACFP ELIGIBILITY APPLICATION - FAMILY DAY CARE HOMES
PROVIDER'S INCOME and PROVIDER'S OWN CHILDREN**

PART IA: Provider's Name:

PART IB : Complete this part if you are claiming your own children.

Child's Name: Last _____ First _____ M.I. _____ Date of Birth _____

Child's Name: Last _____ First _____ M.I. _____ Date of Birth _____

PART 2A - HOUSEHOLD NOW GETTING SNAP, TANF, or FDPIR, BENEFITS: Complete this part and sign the statement in PART 3 - DO NOT complete PART 2B. . If a child or a child's parent is participating in or subsidized under a Federally or State supported child care or other benefit program with an income eligibility limit that does not exceed the eligibility standard for free or reduced price meals, meals served to the child are automatically eligible for tier I reimbursement, subject to the completion of the application.

SNAP case #: _____ TANF identification #: _____

FDPIR identification #: _____
(Food Distribution Program on Indian Reservations)

PART 2B - ALL OTHER HOUSEHOLD MEMBERS: If you did not complete PART 2A, complete this PART and PART 3.

NAMES		CURRENT INCOME/FREQUENCY - (Last Month)		
Names of All Household Members	Earnings from Work (Before Deductions) Job 1	Welfare, Child Support, Alimony	Payments from Pensions, Retirement, Social Security	Earnings from Job 2 or any Other Income

PART 2C - Complete this PART and PART 3. If this is a foster child check here (). Foster children are eligible for free and reduced-price meals regardless of household income. 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.

PART 3 - 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 on the application may subject me to prosecution under applicable state and federal criminal laws.

Signature of DCH Provider: _____ Last Four Digits of Social Security #: _____
(Required) (Required (last 4 digits) for households qualifying by income)

Printed name of DCH Provider: _____ Date Signed: _____

Home Address _____ Zip Code _____ Home Telephone _____ Work Telephone _____

PART 4 - 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

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 Sponsoring Organization Use Only: Verification of SNAP, TANF or FDPIR household categorically eligible for program benefits:
 YES NO

MONTHLY INCOME CONVERSION: WEEKLY X 4.33 EVERY 2 WEEKS X 2.15 TWICE A MONTH X 2

Total family income: _____ Family size: _____
 Tier I _____ Eligible:
 Tier II _____ Not Eligible:
 Sponsor Signature: _____ Date: _____

For state use only:	
Verified by: _____	Date: _____
Verified classification: <input type="checkbox"/> Free <input type="checkbox"/> Reduced <input type="checkbox"/> Denied	
Reason for change in classification: _____	

**CACFP ELIGIBILITY APPLICATION INSTRUCTIONS
FAMILY DAY CARE HOMES**

Please complete the Child and Adult Care Food Program Eligibility Application using the instructions below. Sign the statement and return it to the sponsoring organization listed below. Call the organization if you need help: #

PART 1A: PROVIDER INFORMATION: Complete this part.

- (1) Print the name of the Day Care Home provider.

PART 1B : Complete this part if you are claiming your own children.

PART 2A : HOUSEHOLD GETTING SNAP, TANF, or FDPIR BENEFITS:

Complete this PART and PART 3.

- (1) List your current SNAP, TANF, or FDPIR case number. Do not complete Part 2B.
(2) An adult household member must sign the statement in PART 3.

PART 2B : HOUSEHOLD INCOME: Complete this PART and PART 3

- (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 more or less than usual, write the person's usual income.
(3) An adult household member must sign this income eligibility statement and give his/her social security number in PART 3.

PART 3 - SIGNATURE AND LAST FOUR DIGITS OF THE SOCIAL SECURITY NUMBER: All households complete this PART.

- (1) All eligibility statements must have the 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 FDPIR number a social security number is not needed.

PART 4 – ETHNIC/RACIAL IDENTITY: Complete the Ethnic/Racial identity question.

INCOME TO REPORT

Earnings from Employment

Wages/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

Name and Address of Sponsoring Organization

Dear Day Care Home Provider:

You are participating in the Child and Adult Care Food Program (CACFP) funded by the U.S. Department of Agriculture and administered by the North Carolina Department of Health and Human Services. Please help us comply with the CACFP requirements by completing, signing and returning the attached income statement as soon as possible to your sponsor. This information is necessary so that you may be paid for the meals served to the children in your care. All children in our program receive their meals free of charge, but the income eligibility category determines the amount of funding you will receive. The information you provide on this form will be confidential and will **NOT** be shared with anyone else without your permission.

Complete the application as follows:

- **PROVIDER’S NAME:** Insert your name.
- **CHILDREN:** Complete Part 1B if you are claiming your own children.
- **SNAP, TANF/WORK FIRST, FDIPIR:** If a household member is currently receiving benefits from any of these programs, provide the program case/identification number as requested. Do not complete Part 2B.
- **HOUSEHOLD MEMBERS:** Complete Part 2B if you do not complete Part 2A. List household members, the name of the enrolled child(ren), and any other dependent children who live in the household.
- **CURRENT INCOME:** List the amount of income each person earned **last** month (**BEFORE**) deductions for taxes, social security, etc.), the frequency of income, and where it is from, such as wages, retirement, or welfare. If any household member’s income last month was higher or lower than usual, list that person’s usual average monthly income.
- **SIGNATURE:** An adult household member must sign the income eligibility application.
- **LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER:** List the last four digits of the social security number of the adult who signs the income eligibility statement. If that adult does not have a social security number, print “None.”

**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.

There is now an affordable health insurance program for children, Health Choice, offered by the State of North Carolina. Health Choice is a comprehensive health plan which covers both hospitalization and outpatient care, including preventive dental, vision, and hearing benefits. This new health plan is intended for children whose parents’ income is too high to qualify for Health Check, the state Medicaid program. Applications for Health Choice will be available beginning in October 1998. You may pick up applications from your local health or county social services departments. Get more information on either Health Choice or Health Check by calling this toll free phone number: (800) 367-2229.

**CACFP INCOME ELIGIBILITY
CHILDREN ENROLLED IN FAMILY DAY CARE HOMES**

PARENT/GUARDIAN HOUSEHOLD LETTER

Dear Parent/Guardian:

Your day care provider participates in the Child and Adult Care Food Program (CACFP) funded by the U.S. Department of Agriculture and administered by the North Carolina Department of Health and Human Services. Please help us comply with the CACFP requirements by completing, signing and returning the attached income statement to the address provided. This information is necessary so that your day care provider may be paid for the meals served to the children in their care. All children in our program receive their meals free of charge, but the income eligibility category determines the amount of funding your day care provider will receive. The information you provide on this form will be confidential and will **NOT** be shared with your day care provider or anyone else without your permission.

Complete the application as follows:

- **HOUSEHOLD MEMBERS:** List the name of the enrolled child(ren), and the child's parent(s) or guardian, and any other dependent children who live in the household.
- **SNAP, TANF/WORK FIRST, FDIPIR, WIC, FREE/REDUCED PRICE SCHOOL LUNCH:** If a household member is currently receiving benefits from any of these programs, provide the program case/identification number as requested. Do not complete Part 2B.
- **CURRENT INCOME:** List the amount of income each person earned **last month (BEFORE)** deductions for taxes, social security, etc.), the frequency of income, and where it is from, such as wages, retirement, or welfare. If any household member's income last month was higher or lower than usual, list that person's usual average monthly income.
- **SIGNATURE:** An adult household member must sign the income eligibility application.
- **Last Four Digits of the Social Security Number:** List the last four digits of the social security number of the adult who signs the income eligibility statement. If that adult does not have a social security number, print "None"

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

HOUSEHOLD SIZE	YEARLY	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY
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2	27,214	2,268	1,134	1,047	524
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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.

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**CACFP INCOME ELIGIBILITY APPLICATION INSTRUCTIONS
CHILDREN ENROLLED IN FAMILY DAY CARE HOMES**

PART 1 – PARTICIPANT’S INFORMATION: Complete this part.

- (1) Print the name of each child enrolled in the Day Care Home.
- (2) Print the name of the Day Care Home provider.

PART 2A - HOUSEHOLD GETTING SNAP, TANF/WORK FIRST, FDPIR, NATIONAL SCHOOL LUNCH, SCHOOL BREAKFAST, HEADSTART OR WIC BENEFITS:

Complete this PART and PART 3.

- (1) List your current SNAP case number or your TANF/Work First, FDPIR, or WIC identification number, or check yes to indicate that your child receives free/reduced priced school lunch. Do not complete Part 2B.
- (2) An adult household member must sign the statement in PART 3.

PART 2B - HOUSEHOLD INCOME: Complete this PART and PART 3

- (1) List the names of household members.
- (2) For each household member provide the gross income (the amount before taxes or any other deductions), 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 more or 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 3.

INCOME TO REPORT

Earnings from Employment
Wages/salaries/tips
Strike benefits
Unemployment compensation
Worker’s compensation
Net income from self-owned business or farm

Pensions/Retirement/Social Security
Pensions
Supplemental security income
Retirement income
Veteran’s payments
Social security

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

Welfare/Child Support/Alimony
Public assistance payments
Welfare payments
Alimony/Child support payments

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.)

PART 2C - FOSTER CHILD: Complete this PART and PART 3 for each foster child living in your home and enrolled in the facility. 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.

PART 3 - SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER: All households complete this PART.

- (1) All eligibility statements must have the 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/Work First, WIC, or FDPIR number a social security number is not needed.

PART 4 – ETHNIC/RACIAL IDENTITY: Complete the Ethnic/Racial identity question.

The section below should be returned with the CACFP Eligibility Application if consent is given to the provider to collect this form.

Written Consent Clause: Provider’s Name: _____

If you choose to complete the CACFP Eligibility Application, you have the option of returning it directly to your Provider or to the Provider’s Sponsor. If you want to provide the CACFP Eligibility Application directly to the sponsor, return the completed form to:

Name and Address of Sponsoring Organization

_____ Initial here if you consent to allowing _____ to collect your form and provide it to
(Provider’s Name)
the Sponsor. _____ will not review your form.
(Provider’s Name)



UNITED STATES MARINE CORPS

Marine Corps Community Services
Children, Youth and Teen Programs
Bldg AS-1000 Curtis Road
Marine Corps Air Station New River,
Jacksonville, North Carolina 28545-1001

October 26, 2009

Dear Parents:

Providing your infant with a safe environment in which to grow and learn is of extreme importance to us. To that end, Children, Youth and Teen Programs (CYTP) have implemented policies and procedures to create a safe sleep environment for your infant.

We follow the recommendations of the American Academy of Pediatric and the MCOP1710.30E for safe sleep environments to reduce the risk of sudden infant death syndrome (SIDS). SIDS is the “sudden death of an infant under 1 year of age, which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history.”

Our written policy includes the following:

- ❖ All infants will be placed on their backs in safety-approved cribs unless an alternate position is needed for a medical reason and a written note from the infant’s health professional is provided.
- ❖ Infants will not sleep on water beds, sofas, soft mattresses, or other soft surfaces.
- ❖ Soft material such as pillows, quilts, comforters, sheepskins, stuffed toys, and loose bedding will not be placed in infants’ sleep environment.
- ❖ Infants will not share a safety-approved crib with other children.
- ❖ Infants will remain lightly clothed and comfortable while sleeping.
- ❖ Supervised “tummy time” will be observed while infant is awake.
- ❖ CYTP environments and the surrounding area are smoke-free.

Again, safety of your infant is paramount to us. By signing below, you, as a parent, understand and comply with the policies of the Children, Youth and Teen Programs, which your child will be attending.

Parent’ Signature

Date

Program Manager’ Signature

Date