



24 Hour Childcare Center

Registration Packet

Our staff never stops caring for the children of the Wyoming Valley. The CYC Childcare Program begins early Monday morning and continues operation 24 hours a day through Saturday morning. The program is designed to accommodate parents who work 1st, 2nd, or 3rd shift. Children 6 weeks through school age may be enrolled.

We have access to the entire CYC facility which includes 2 gymnasiums, 2 playgrounds, outdoor park, swimming pool, and a library. The CYC is an equal opportunity childcare provider. Applications for enrollment are accepted without regard to race, religion, sex, disability, or national origin.



INFANT/TODDLER

6 Weeks - 12 Months

LITTLE LEARNERS

2 - 3 Years

PRE-SCHOOL

3^{1/2} - 4 Years



SCHOOL AGE

5 - 13 Years

NEW BEGINNINGS

12 Months - 2 Years

PRE-SCHOOL PREP

3 - 3^{1/2} Years

KINDERTOT

4 - 5 Years



Catholic Youth Center 36 South Washington St. Wilkes-Barre, Pa. 18701

www.cycwb.org 570-823-6121



facebook.com/catholicyouthcenter

EMERGENCY CONTACT / PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124(a)(b), 3270.181 & 182, 3280.124 (a)(b), 3280.181 & 182; 3290.124 (a)(b), 3290.181 & 182

CHILD'S NAME		BIRTHDATE
ADDRESS		
MOTHER'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER
ADDRESS		
BUSINESS NAME		BUSINESS TELEPHONE NUMBER
ADDRESS		
FATHER'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER
ADDRESS		
BUSINESS NAME		BUSINESS TELEPHONE NUMBER
ADDRESS		
EMERGENCY CONTACT PERSON(S)	NAME	TELEPHONE NUMBER WHEN CHILD IS IN CARE
PERSON(S) TO WHOM CHILD MAY BE RELEASED	NAME	ADDRESS
	TELEPHONE NUMBER WHEN CHILD IS IN CARE	
NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER		TELEPHONE NUMBER
ADDRESS		
SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTION)	
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICATION, SPECIAL CONDITIONS	
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD		
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS		POLICY NUMBER (REQUIRED)
PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT		
OBTAINING EMERGENCY MEDICAL CARE	ADMIN. OF MINOR FIRST - AID PROCEDURES	
WALKS AND TRIPS	SWIMMING	
TRANSPORTATION BY THE FACILITY	WADING	

PERIODIC REVIEW

SIGNATURE OF PARENT or GUARDIAN

DATE

SIGNATURE OF PARENT or GUARDIAN

DATE



Childcare Payment Policy

At the time of enrollment, parents are required to sign an agreement stating the following:

- Days and Hours of Care
- Weekly Tuition
- Transportation (School Age program)
- Services Provided by CYC

In order to register at the CYC Childcare Center, each family **MUST** pay the first week's tuition and a deposit equal to the weekly fee. Each student's childcare tuition is an ongoing fee which is due the Friday **PRIOR** to the week of service. Childcare fees are due each week regardless of student attendance if your child is enrolled in the program. The CYC accepts the following forms of payment: Checks, Money Orders, Cash, or Credit/Debit Cards (Mastercard/Visa/Discover/American Express).

The following is our procedure when fees are not paid

- On Friday of the first week not paid: Late notice sent to the family including a \$10.00 late fee.
- On the second consecutive Friday when fees have not been paid: A termination notice is issued with services ceasing on the following Monday. An additional late fee of \$10.00 will be assessed. A child will not be permitted back into the facility until the entire balance is paid in full.
- Families receiving a scholarship through United Way funding who falls more than two weeks behind with their tuition payments will be immediately lose the scholarship and will not be eligible to re-apply for a period of six months.
- Families receiving subsidies through ELRC must pay their fees each week. Any family who does not pay their fee will be reported to ELRC on Monday following delinquency. This could jeopardize your ongoing subsidy.

PLEASE NOTE: If childcare services are terminated for non-payment, your child's spot may be given to another family on our waiting list.

I, _____ (Parent/Guardian), acknowledge the receipt and understanding of this policy. I understand that if I do not adhere to this policy, all childcare services for _____ (Child's Name) will be terminated as stated above. A copy of this policy is also located at the main office and if requested, a copy will be provided to you.

Catholic Youth Center
36 South Washington Street, Wilkes-Barre, Pa. 18701
Phone: 570-823-6121 www.cycwb.org



CHILDCARE CENTER

Dear Parents or Guardian,

The Pennsylvania Department of Human Services (DHS) require that all parents/guardians of children enrolled in Childcare Centers provide an initial health report and current shot record no later than 60 days following the first day of attendance at the facility.

PLEASE NOTE:

1. The initial report for an infant from birth to one year of age must be dated no more than 3 months prior to the first day of attendance at the facility.
2. The initial health report for a young toddler from ages 1 to 2 years of age must be dated no more than 6 months prior to the first day of attendance at the facility.
3. The initial health report for an older toddler ages 2 to 3 years old and a preschool child from age 3 to 6 years of age must be dated no more than a year prior to the first day of attendance at the facility.
4. The initial health report for school-age children must be current. To be considered current, health reports for children age 3-6 years are required yearly until the child has had a health report done at the age of 6 (and has entered school) this is required every two years thereafter.

ADDITIONALLY, an updated health report must then be provided at least every 6 months for an infant or young toddler, every 12 months for an older toddler or preschool age child, and yearly for a school-age child. The health report must be written and signed by a physician, physician's assistant or CRNP. The signature must include the individual's professional title. Updates to the immunization record must be provided whenever immunizations are administered.

Please ask your health care provider to be sure to complete all sections of the child's health report. It is important that no information be omitted since DHS regulations require us to have all information accurate.

The health report for your child _____
must be completed by _____ and returned to the childcare facility immediately thereafter. **Remember that a current shot record must be included.**

PLEASE NOTE THAT FAILURE TO PROVIDE ALL REQUIRED INFORMATION BY THE DEADLINE THAT IS GIVEN WILL RESULT IN TERMINATION OF SERVICES.



Rev. John S. Terry, Director

Mr. Mark J. Soprano, Executive Director

Dear Parents and Guardians,

From time to time at the CYC Child Care Center, we take pictures of the children enrolled for publicity purposes. These pictures will be used for local newspapers and for the CYC website and publicity materials. There is also the potential for video to be taken of children for various news stories by local television stations. Below is the permission slip for your child to appear in the above mentioned areas.

CHILD'S NAME

Yes, I grant my permission for my child's photograph to appear within local newspapers and television stories as well as the CYC website and publicity materials.

No, I do not grant my permission for my child to appear in any publicity.

PARENT/GUARDIAN SIGNATURE

36 South Washington Street, Wilkes-Barre, PA 18701
Phone: (570) 823-6121 Fax: (570) 823-0175
www.wyomingvalleycyc.org



CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:
<input type="checkbox"/> I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.		
PARENT'S SIGNATURE:		

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
 NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
 NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
 NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
 NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
 YES NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG) <input type="checkbox"/> YES <input type="checkbox"/> NO	<p>NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">VISION (subjective until age 3)</td> <td></td> </tr> <tr> <td>HEARING (subjective until age 4)</td> <td></td> </tr> <tr> <td>LEAD</td> <td></td> </tr> </table>	VISION (subjective until age 3)		HEARING (subjective until age 4)		LEAD	
VISION (subjective until age 3)							
HEARING (subjective until age 4)							
LEAD							

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.

**Child and Adult Care Food Program
Child Enrollment Form (Sample)**

Sponsor: _____
Center: _____

ENROLLMENT FORM FOR CHILDREN IN CHILD CARE (SAMPLE)

This document does not have to be completed for children in Emergency Shelters, Outside School Hours, and/or At-Risk programs. It is recommended to have new CACFP Annual Enrollment Forms completed each year during the Household Eligibility Application renewal period. Review completed enrollment form and enter the effective date in lower right hand section.

PARENTS: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents and guardians to complete a CACFP Annual Enrollment Form when enrolling their child(ren) and again every year thereafter. This information will help ensure all children receive appropriate meals during their care. Please complete all areas to include signing and dating same.

FULL NAME OF ENROLLED CHILD (include Birth Date/Age)	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FIRST CHILD	<input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY	<input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours Other: _____								<input type="checkbox"/> BREAKFAST <input type="checkbox"/> A.M. SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK
NAME		Enrollment Date: _____ Withdrawal Date: _____								
BIRTH DATE		<input type="checkbox"/> Same Times as Above <input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours Other: _____								
AGE		TIMES CHILD NORMALLY ATTENDS DURING WEEK TIME-IN TIME OUT TIME CHILD ATTENDS SCHOOL AM PM TIME AM PM TIME LEAVES CENTER RETURNS TO CENTER								
SECOND CHILD	<input type="checkbox"/> Same as Above <input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY	<input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours Other: _____								<input type="checkbox"/> Same Meals as Above <input type="checkbox"/> BREAKFAST <input type="checkbox"/> A.M. SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK
NAME		Enrollment Date: _____ Withdrawal Date: _____								
BIRTH DATE		<input type="checkbox"/> Same Times as Above <input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours Other: _____								
AGE		TIMES CHILD NORMALLY ATTENDS DURING WEEK TIME-IN TIME OUT TIME CHILD ATTENDS SCHOOL AM PM TIME AM PM TIME LEAVES CENTER RETURNS TO CENTER								
THIRD CHILD	<input type="checkbox"/> Same as Above <input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY	<input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours Other: _____								<input type="checkbox"/> Same Meals as Above <input type="checkbox"/> BREAKFAST <input type="checkbox"/> A.M. SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK
NAME		Enrollment Date: _____ Withdrawal Date: _____								
BIRTH DATE		<input type="checkbox"/> Same Times as Above <input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours Other: _____								
AGE		TIMES CHILD NORMALLY ATTENDS DURING WEEK TIME-IN TIME OUT TIME CHILD ATTENDS SCHOOL AM PM TIME AM PM TIME LEAVES CENTER RETURNS TO CENTER								
FOURTH CHILD	<input type="checkbox"/> Same as Above <input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY	<input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours Other: _____								<input type="checkbox"/> Same Meals as Above <input type="checkbox"/> BREAKFAST <input type="checkbox"/> A.M. SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK
NAME		Enrollment Date: _____ Withdrawal Date: _____								
BIRTH DATE		<input type="checkbox"/> Same Times as Above <input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours Other: _____								
AGE		TIMES CHILD NORMALLY ATTENDS DURING WEEK TIME-IN TIME OUT TIME CHILD ATTENDS SCHOOL AM PM TIME AM PM TIME LEAVES CENTER RETURNS TO CENTER								
FIFTH CHILD	<input type="checkbox"/> Same as Above <input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY	<input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours Other: _____								<input type="checkbox"/> Same Meals as Above <input type="checkbox"/> BREAKFAST <input type="checkbox"/> A.M. SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK
NAME		Enrollment Date: _____ Withdrawal Date: _____								
BIRTH DATE		<input type="checkbox"/> Same Times as Above <input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours Other: _____								
AGE		TIMES CHILD NORMALLY ATTENDS DURING WEEK TIME-IN TIME OUT TIME CHILD ATTENDS SCHOOL AM PM TIME AM PM TIME LEAVES CENTER RETURNS TO CENTER								

Signature

Signature of Parent or Guardian

Date

Telephone Number of Parent or Guardian

CHILD CARE REPRESENTATIVE USE ONLY:

Name of Representative/Signature

Date

The effective date can be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.

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

Annual Time Period Covered by Signature: _____ to _____

Signature Parent/Guardian _____ Date _____

Signature Center Administrator/Home Provider _____ Date _____

Annual Time Period Covered by Signature: _____ to _____

Signature Parent/Guardian _____ Date _____

Signature Center Administrator/Home Provider _____ Date _____

Annual Time Period Covered by Signature: _____ to _____

Signature Parent/Guardian _____ Date _____

Signature Center Administrator/Home Provider _____ Date _____

Annual Time Period Covered by Signature: _____ to _____

Signature Parent/Guardian _____ Date _____

Signature Center Administrator/Home Provider _____ Date _____

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

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

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800)877-8339; or (800) 845-6136 (Spanish).

USDA is an equal opportunity provider and employer.

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

Part 1. All Household Members	Check if a foster child (the legal responsibility of a welfare agency or court) * If all children listed below are foster children, skip to Part 5 to sign this form.	Check if NO income
Names of Enrolled Child(ren) (First, Middle Initial, Last)	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

Names of all Household Members (First, Middle Initial, Last)	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

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

NAME: _____ CASE NUMBER: _____

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

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

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

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

An adult household member must sign this form. If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.)

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

Sign Here: _____ Print Name: _____ Date: _____

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

Phone Number: _____

Last four digits of Social Security Number: * * * - * * - _____ I do not have a Social Security Number

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

Mark one ethnic identity:

- Hispanic or Latino
 Not Hispanic or Latino

Mark one or more racial identities:

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

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

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

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

Categorical Eligibility: _____ Eligibility: Free Reduced Denied (Paid) Date Withdrawn: _____

Reason for Denied:

Determining Official's Signature:

Date: _____

Confirming Official's Signature:

Date: _____

Follow-up Official's Signature:

Date: _____

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

Household size	Yearly
1	\$21,775
2	\$29,471
3	\$37,167
4	\$44,863
5	\$52,559
6	\$60,255
7	\$67,951
8	\$75,647
Each additional person:	+\$7,696

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

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

**Instructions For Completing the CACFP
Child Care Center Meal Benefit Income Eligibility Form**

Follow these instructions, if your household gets SNAP, TANF or FDPIR:

Part 1: List all enrolled children and household members.

Part 2: List the case number for any household members (including adults) receiving **State SNAP** or **State TANF** or **FDPIR** benefits.

Part 3: Skip this part.

Part 4: Skip this part.

Part 5: Sign the form. The last four digits of a Social Security Number are not necessary.

Part 6: Answer this question if you choose.

FOSTER CHILDREN HOUSEHOLDS, will follow these instructions:

A Meal Benefit Form is not required to be completed. Contact the center at [insert sponsor telephone number]; OR

If some of the children in the household are foster children:

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster child.

Part 2: If the household does not have a case number, skip this part.

Part 3: If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call [your school, homeless liaison, migrant coordinator]. If not, skip this part.

Part 4: Follow these instructions to report total household income for this month or last month.

Column A – Name: List only the first and last name of each person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the **gross income**, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.

Box 2: List the amount each person got for the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, report income after expenses in Box 1. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if she/he doesn't have one.

Part 6: Answer this question if you choose.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box."

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Follow these instructions to report total household income for this month or last month.

Column A – Name: List only the first and last name of each person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.

Box 2: List the amount each person got for the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, report income after expenses in Box 1. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if she/he doesn't have one.

Part 6: Answer this question if you choose.

Privacy Act Statement: This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.