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FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

All information is required. If an item is not applicable to your child, please write "None" or "N/A".

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	BIRTH DATE
ADDRESS	**Entering Grade _____ in Fall 2016**
MOTHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
E-MAIL ADDRESS	MOBILE TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	
FATHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
E-MAIL ADDRESS	MOBILE 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 REACTIONS)
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)

PARENTS 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

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CHILD CARE SERVICES AGREEMENT

55 PA CODE CHAPTERS 3270.123 & 181(c); 3290.123 & 181(c)

Please leave this form blank. You will go over the terms of your agreement with the Child Care Director before your child's start date.

NAME OF CHILD		
FEE AMOUNT	**PER-DAY WEEK**	**DAY PAYMENT TO BE MADE**
Services to be provided as part of the child care fee: Breakfast served from 7:30-9:00 a.m., lunch, afternoon snack. **$25 Annual Registration Fee per child**		
CHILD'S ARRIVAL TIME	**CHILD'S DEPARTURE TIME**	**PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED:**
LATE FEE $5 charge at 6:05 p.m.	**PER MIN-HR** After 6:05, a $10 fee will be charged every five minutes.	

I, THE PARENT/GUARDIAN;

☐ **RECEIVED COMPLETE WRITTEN PROGRAM INFORMATION AT THE TIME OF ENROLLMENT (PA DPW Code 3270.121, 3290.121, 3290.121)**

☐ **AGREE TO UPDATE THIS EMERGENCY CONTACT/PARENTAL CONSENT FORM INFORMATION WHENEVER CHANGES OCCUR OR EVERY 6 MONTHS AT A MINIMUM. (PA DPW Code 3270.124, 3280.124, 3290.124)**

_____ _____

SIGNATURE - OPERATOR **DATE** **SIGNATURE - PARENT OR GUARDIAN** **DATE**

DATE OF CHILD'S ADMISSION	PERIODIC REVIEW – sign every 6 months
	_____ _____ **SIGNATURE - PARENT OR GUARDIAN** **DATE**
DATE OF WITHDRAWAL	_____ _____ **SIGNATURE – PARENT OR GUARDIAN** **DATE**

This form must be completed by your child's physician and returned to us within 30 days of your child's enrollment date.

CHILD HEALTH REPORT
(55 PA CODE ss3270.131, 3280.131 and 290.131)

Child's Name: (Last) (First)	**Parent/Guardian:**
Date of Birth: Home Phone:	**Address:**
Child Care Facility Name: Beaver County YMCA	
Facility Phone: 724-891-8439 County: Beaver	**Work Phone:**

☐ **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.**

Parents Signature:

Do not omit any information

This form must be completed 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 sheet 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) ☐ **Yes** ☐ **No**	**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**	
	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:**

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PARENT STATEMENT OF UNDERSTANDING

I have reviewed the Parent Handbook (located at the end of enrollment packet) and acknowledge that it is my responsibility to review the handbook and comply with the policies. If I have questions regarding a specific area of content, a YMCA staff member will clarify for me.

Parent Name (printed): _____

Parent Signature: _____

Date: _____

YMCA SUMMER CAMP 2018 FIELD TRIPS

The YMCA summer camp program will be offering 4 exciting opportunities for your child to experience some additional fun this summer! For **ALL** field trips the bus will leave from the Beaver County YMCA at 9:00 and will return at approximately 3:30pm.

For Camp only participants, 9:00am - 4:00pm: Please plan on dropping off promptly at 9:00am, and waiting until 4:00pm to pick up at the end of the day.

Before and After camp care, 6:00-9:00 am & 4:00-6:00pm will be available on field trip days.

We will be visiting the **Midland pool** twice this summer, **Friday June 29th**. Our campers will have the opportunity to enjoy the outdoor pool and playground.

On **Friday, July 20th** we will be traveling to **Raccoon State Park.** We will leave the YMCA at 9:00am. A State Park Ranger will lead each group through an environmental exploration during the morning. After lunch we will be enjoying the park as we play group games and sports.

Our third Field trip will be on **Friday, August 3rdh** at **Brady's Run Park**.

A picnic style lunch will be served on all field trips, and an afternoon snack will also be provided.

Please detach the bottom of this sheet and return it to your child's group teacher no later than **Wednesday, June 20th.** Please complete the form regardless of whether your child will, or will not be attending fieldtrips. **IMPORTANT: IF YOU HAVE MORE THAN ONE CHILD WHO IS ATTENDING, PLEASE COMPLETE A SEPARATE FORM FOR EACH CHILD.**

I give my child, _____, permission to attend the
(print child's name above)
following field trip(s), please initial:

_____ June 29, 2018 – Midland Pool

_____ July 20, 2018 – Raccoon State Park

_____ August 3rd, 2018 – Brady's Run

_____ My child will NOT be attending a YMCA fieldtrip

Parent Name (Please Print)_____

Parent Signature_____

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Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. **Beaver County YMCA** offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached Meal Benefit Income Eligibility Form. In addition, by filling out this form, we will be able to determine if your child(ren) qualifies for free or reduced price meals.

1. **Do I need to fill out a Meal Benefit Form for each of my children in day care?** You may complete and submit one CACFP Meal Benefit Income Eligibility Form for all children enrolled in child care in your household **only** if the children in child care are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. **Return the completed form to: Beaver County YMCA Child Care Center, 2236 Third Avenue, New Brighton, PA 15066.**

2. **Who can get free meals without providing income information?** Children in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) benefits can get free meals. Foster children and children enrolled in Head Start are also eligible for free meals. Children in households participating in WIC may be eligible for free meals.

3. **Who can get reduced price meals?** Your children can get low cost meals if your household income is within the reduced price limits on the Federal Income Chart, shown on this application. Children in households participating in WIC may be eligible for reduced price meals.

4. **May I fill out a form if someone in my household is not a U.S. citizen?** Yes. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center.

5. **Who should I include as members of my household?** You must include everyone in your household (such as grandparents, other relatives, or friends who live with you) who shares income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you.

6. **How do I report income information and changes in employment status?** The income you report must be the total gross income listed, by source, each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income Chart, the center will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or by providing a current SNAP, TANF, or FDPIR case number, you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the eligibility standards.

7. **What if my income is not always the same?** List the amount that you normally get. For example, if you normally get $1000 each month, but you missed some work last month and only got $900, put down that you get $1000 per month. If you normally get overtime, include it, but not if you only get it sometimes.

8. **What if I have foster children?** Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the Meal Benefit Form, but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children should contact our Child Care Director at 724-891-8439.

9. **We are in the military, do we include our housing and supplemental allowances as income?** If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex, age or disability.

If you have other questions or need help, please call me at 724-891-8439 or email me at thamilton.ymca@gmail.com.

Sincerely,

Child Care Director

This form is required for all children enrolled in the center. Use one form for all children enrolled from your household.

Child and Adult Care Food Program
Child Enrollment Form

Sponsor: Beaver County YMCA
Center: Beaver County YMCA

ENROLLMENT FORM FOR CHILDREN IN CHILD CARE

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

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

Please complete all areas to include signing and dating same.

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

Signature _____ _____ _____

Signature of Parent or Guardian *Date* *Telephone Number of Parent or Guardian*

CHILD CARE REPRESENTATIVE USE ONLY: _____ _____

Name of Representative/Signature *Date*

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

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

Annual Time Period Covered by Signature: ___________________ **to** ___________________
Signature Parent/Guardian____ **Date** ____________________
Signature Center Administrator/Home Provider___________________________ **Date** ____________________
****

Annual Time Period Covered by Signature: ___________________ **to** ___________________
Signature Parent/Guardian____ **Date** ____________________
Signature Center Administrator/Home Provider___________________________ **Date** ____________________
****

Annual Time Period Covered by Signature: ___________________ **to** ___________________
Signature Parent/Guardian____ **Date** ____________________
Signature Center Administrator/Home Provider___________________________ **Date** ____________________
****

Annual Time Period Covered by Signature: ___________________ **to** ___________________
Signature Parent/Guardian____ **Date** ____________________
Signature Center Administrator/Home Provider___________________________ **Date** ____________________
****

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 *(724) 891=8439*; 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.

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

Part 1. All Household Members

Name of Enrolled Child(ren):

Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

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

	B. Gross income and how often it was received			
A. Name (List **only** household members with income)	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 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the back of this page.)

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

Sign Here: _____ Print Name: _____

Date: _____

Address: _____ Phone Number: _____

City:_____ State: _____ Zip Code: _____

Last four digits of Social Security Number: _*_*_*-_*_*-__ __ __ __ ☐ I do not have a Social Security Number