FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Dear Families,

Thank you for your interest in enrolling your child(ren) in our Preschool Program. Our Preschool Program offers new and exciting experiences that will keep your child active, learning, and bonding with peers throughout the year.

Enclosed in this packet you will find the forms and documentation needed for registration. Enrollment will be based on licensed capacity approved by the state availability.

All pages of the enrollment packet **MUST** be completed to enroll your child(ren). You will not be enrolled until all paperwork is submitted and you receive confirmation of enrollment and your child's first official day. All portions of the emergency contact form must be completed (names, addresses, and phone numbers.) State Licensing requires the Child Health Report must be submitted with all sections completed by a physician including the immunization portion. If you choose not to immunize your child(ren) for any of the required childhood immunizations, you **MUST** provide a signed statement of your choice with the Child Health Report. Packets must be completed and turned in at least **10 business days prior to your child's anticipated start date.**

If you have any questions, please reach out to us!

Thank you,

Barb Thornton

Barb Thornton
Director of Youth & Family Programs
barbthornton@icymca.org

Unless otherwise noted, all forms are required and must be filled out and turned in together. We will **NOT** accept incomplete enrollment packets.

- Registration Form
- Emergency Contact Form
- Agreement Form
- EFT Form, Tax, Parent Handbook and Payment Policy
- YMCA of Indiana County Waiver
- Child Health Form
- CACFP Meal Benefit Income Eligibility (Child Care) Form

Completed applications should turned in at the YMCA of Indiana County Welcome Center.

Received on:_____ MSR Initials:_____

2023 Preschool Registration

Child's Name _____ **Birthdate** ____/_____/_____

Age _____ ☐**Male**☐**Female**☐**Other:**_____

Address _____ **City** _____ **Zip** _____

Parent/Guardian Name: _____ **Work Phone** _____

Email address (required) _____ **Cell Phone** _____

Registration Fee: $30 per camper, non-refundable. Sibling discount applies.
Are you a current or new ELRC *recipient?* ☐**YES** ☐**NO**

***All required paperwork is due 10 days prior to anticipated enrollment date.**

Please list any medical conditions or allergies that we should be aware of. If none, please put N/A

_____
_____
_____
_____

_____ _____

Parent/Guardian Signature **Date**

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	DATE OF BIRTH
ADDRESS	

PARENT'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER ( )
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	

PARENT'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 SITUATION
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 _____

WHITE COPY (Original) **YELLOW COPY** (Child Care Space) **PINK COPY** (Excursion)

EMERGENCY CONTACT/CONSENT FORM

This form should always be readily available and travel with the child in the event of a medical emergency.

Child's Name	Primary Guardian's Name

By checking and signing each box below, the guardian has provided consent for the YMCA of Bucks & Hunterdon Counties to provide the following. Consent is required for items listed with an asterisk (*).

_____ Obtaining **Emergency Medical Care*** **Signature: _____**	_____ Administration of **Minor First Aid*** **Signature: _____**
_____ Short **Walks** **Signature: _____**	_____ **Trips** (Only when advanced notice is provided) **Signature: _____**
_____ **Emergency Transportation** by the Facility* (Utilized for emergency relocation) **Signature: _____**	
_____ Participation in **Swimming** (Children 3+ only) **Signature: _____**	
_____ Administration of **Non-Prescription Medications** (A separate medication form is required for each medication) **Signature: _____**	_____ Administration of **Prescription Medications** (A separate medication form is required for each medication) **Signature: _____**
_____ Administration of **facility generic sunscreen** _____ Administration of **family provided sunscreen** **Signature: _____**	_____ Administration of **facility generic Deet-Free Insect Repellent** _____ Administration of family provided **Deet-Free Insect Repellent** **Signature: _____**

Per state regulations, every six (6) months the legal guardian must reaffirm that all emergency contact information is up to date on page one (1) of this form and acknowledge that they continue to provide the permissions on page two (2). The legal guardian is responsible for updating these pages immediately, if any changes are to occur.

Legal Guardian's Printed Name:	Legal Guardian's Signature	**Initial Date**
Legal Guardian's Printed Name:	Legal Guardian's Signature	**Review Date**
Legal Guardian's Printed Name:	Legal Guardian's Signature	**Review Date**

AGREEMENT

55 PA CODE CHAPTERS 3270.123 181 (C); 3280.123 181(C); 3290.123 181(C)

NAME OF CHILD:	BIRTHDATE:

Payment due date: WEEKLY payments will be drafted on Thursday prior to care or MONTHLY by the 1st of the month.

Late Pick-up Fee: first five (5) minutes- $15; $1 per minute for each additional minute

Late Payment Fee: $30 if payment is not received by Thursday prior to care.

Processing Fee: Drafting from a bank/credit card on file with the YMCA of Indiana County. Should any pre-authorized draft not be honored by the named bank/credit card company when received by them, then it is understood that the payment will be represented electronically and incur a $30 fee.

Enrollment Options:

Full-time, five (5) days per week

Hours are: 7:30 am-5:30 pm

Full-time fee:

$210 per week or $910 per month

ELRC Recipient:

ELRC Co-pay and any remaining balance of the weekly fee after ELRC is applied. Can apply for YMCA Financial Assistance to help with remaining balance. Any amount not covered by ELRC, will be drafted two weeks after ELRC payment is applied, notification will be sent by email with the draft details.

Financial Assistance:

Parent/Guardian is responsible for paying the remaining balance of the weekly fee after YMCA Financial Assistance Scholarship is applied.

Services to be provided as part of the day care fee: (examples transportation, care, meals, etc.)

Chlld care Meals (breakfast, lunch) Afternoon Snack

CHILD'S ARRIVAL TIME:	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED (MUST MATCH PEOPLE ON EMERGENCY CONTACT FORM):
CHILD'S DEPARTURE TIME:	

I, the parent/guardian:

☐ received complete written information at the time of enrollment (3270.121, 3280.121, 3290.121)

☐ agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minimum (3270.124, 3280.124, 3290.124)

YMCA Admin. Signature Date:	PARENT/GUARDIAN SIGNATURE DATE

DATE OF CHILD'S ADMISSION	PERIODIC REVIEW
DATE OF WITHDRAWAL	SIGNATURE OF PARENT OR GUARDIAN DATE

Electronic Funds Transfer Child Care Account Tax Statement
Parent Handbook & Payment Policy Acknowledgement

How does Electronic Funds Transfer (EFT) work?
Once you enroll in EX-EFT, your financial institution will automatically send us your payment from your credit card, checking account, or savings account.

To Enroll: Complete the information below to enroll your child.

Child's Name _____Birth Date _____/_____/_____

Your Name (as appears on card) _____

Choose One:

☐ Checking Account (voided check MUST be attached)

☐ Credit Card ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Card Number _____ Expiration Date _____

Payment Options:

☐ Weekly EFT (collected each Thursday for the following week)
☐ Monthly EFT (collected the first day of each month for that month)

I understand that I am in full control of my payment and if at any time I decide to make changes or discontinue this service, I will notify the YMCA of Indiana County in writing two weeks in advance. Changes of payment method will not affect the terms of my contract. Please note that it is the account holder's responsibility to notify the billing department with any changes to their account. If an account is rejected for any reason, including expired credit cards, you will be assessed an NSF fee of $30.

_____ _____
Account Holder's Signature Date

Child Care Account Tax Statement Requests: (all statements will be completed no later than January 31)

Child Care Tax Statements are available by logging into your account online at icymca.org or by emailing Stephanie at stephaniebrady@icymca.org

This is to acknowledge that I have received a copy of the YMCA Parent Handbook and YMCA of Indiana County Payment Policies. I understand that it outlines my privileges and obligations as a participant in this program.

Parent/Guardian Name (Please Print):_____

Signature:_____ Date: _____

Topics to make note of:

- Authorization for Pickup: must be on the child's emergency contact list and must be at least 18 years of age with a valid photo ID
- Unattended Child Law: A person in charge of a motor vehicle may not permit a child six years of age to remain unattended in a vehicle out of sight and/or under circumstances which endanger the health, safety or welfare of a child.
- Staff Code of Conduct: Staff on mandated reporters. If we suspect any abuse or neglect of a child it our legal responsibility to file a report.

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Financial Terms and Conditions:

1. A non-refundable administration fee of $30 per child is due upon registration.

2. I understand that tuition is due the first of the month or the Thursday prior to care. Payments made after the due date will include a $30 late fee charge.

3. I understand that there will be a $15.00 for the first 5 minutes per child late fee for children not picked up prior to the closing time of the center and an additional $1 per minute after that. Recurring lateness may result in dis-enrollment from the program.

4. I understand that the Y will not pro-rate for days children are off from care such as: holidays, personal vacations, and closures due to Acts of God. Fees for children are to be paid whether the child is in attendance, out sick, or on vacation.

5. If I am on ELRC (formally CCIS/Apple) subsidy:
    a. I am responsible to remain within the allotted 40 days of absences approved by ELRC.
    b. I am further responsible for payment for any care outside of the allotted 40 absences approved by ELRC.
    c. I will be charged full price for any days I bring my child which are not approved by ELRC for subsidy. (Example: ELRC will pay for M-W-F, but parent/guardian drops child off on Thursday.)

6. I understand that refund requests due to serious illness will be considered on a case by case base basis and require a note from a physician within 1-week post illness.

7. I understand that if I have missed 2 weeks of payments, my child will be un-enrolled from the program.

8. Auto-draft is the required method of payment. A Credit card or bank draft must be placed on file.

9. I acknowledge that the most up to date version of that the Parent Handbook is available online at www.icymca.org and I agree to abide by the all terms and conditions set forth within the handbook.

10. I agree that the YMCA shall not be responsible for any personal injuries or losses sustained by my child while on any YMCA premises or as a result of any YMCA sponsored activities. I further agree to indemnify and save harmless the YMCA for any claims or demands arising out of any such injuries or losses.

11. Payments will be drafted from my account on the due date for each week that my child is registered for. I will be responsible for all payments from my account and will notify YMCA of Indiana County of any changes to my account. Should any draft not be honored by my bank for any reason, I realize that I am still responsible for that payment, plus subject to any late or overdraft charges applied by the organization. The current return draft fee is $30.00. This is in addition to any service fee my bank may charge.

12. I understand that if I do not pay in-full for care by the payment due date, that I hereby give authority to YMCA of Indiana County to use the credit card or bank draft on file to charge me for any fees that are currently due.

Child's Name:_____

Guardian's Signature: _____ Date: _____

Guardian's Printed Name: _____

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Guardian Statement of Understanding:

The following information is important for the safety and protection of your child:

- I understand that my child will not be allowed to leave the program with an unauthorized person. Any person authorized to pick up my child including older siblings or other relatives must be listed with the YMCA. Any other arrangements must be made by calling the YMCA preschool to inform them of a change.
- I understand that YMCA staff and volunteers are not allowed to baby-sit or transport children at any time outside the YMCA program. Immediate disciplinary action will be taken by the YMCA toward staff and volunteers if a violation is discovered.
- No care changes may be made mid-month.
- I understand that I am not to leave my young child or children at the YMCA or program site unless a YMCA staff or volunteer is there to receive and supervise my child.
- I understand children should not receive excessive gifts (e.g., TV, video games, jewelry) from YMCA staff or volunteers, and I should report this to a supervisor if they do.
- I understand that should a person arrive to pick up my child who appears to be under the influence of drugs or alcohol, for the child's safety, staff may have no recourse but to contact the police.
- I understand that I can help ensure my child's safety by taking an active interest in his or her YMCA experience.
- I understand that the YMCA is mandated by state law to report any suspected cases of child abuse or neglect to the appropriate authorities for investigation.
- I understand that if my child brings medication to care (including inhalers), that I must sign it in with the office or site supervisor.
- I understand that my child may be dismissed from the program if his/her actions are contrary to the core values of the YMCA or violate any section of the handbook. All efforts will be made to help children with a successful time at the Y. No refunds or credits will be given.
- I understand I will not use social media as a platform to express any potential frustrations and/or concerns regarding care; instead, I will collaborate with leadership in working towards a positive solution.
- I have received a copy of the YMCA Parent Handbook and will keep it for future reference.

WAIVER AND RELEASE

In consideration of my/our participation in the activities of the YMCA OF INDIANA COUNTY, I/we do hereby hold free from any liability YMCA OF INDIANA COUNTY, it's directors, officers, employees and members, including but not limited to its (or their) own negligence, and do hereby for myself/ourselves, heirs, executors and administrators, waive, release and forever discharge any and all rights and claims for damages which I/we may have or which may hereafter accrue to me/us arising from my/our use of or connected with my/our participation in any of the activities of YMCA OF INDIANA COUNTY, it's facilities, equipment or program activities.

Child's Name:_____

Guardian's Signature: _____ Date: _____

Guardian's Printed Name: _____

YMCA of Indiana County Standard Membership/Program Waiver

PHOTO RELEASE AND ADULT AND FAMILY WAIVER, RELEASE FROM LIABILITY, INDEMNIFICATION OF ALL CLAIMS, AND COVENANT NOT TO SUE

I hereby agree that the YMCA may photograph or capture footage of me or members of my household at the YMCA or an any affiliated YMCA property and the YMCA may use those photographs or footage for its marketing purposes and further agree to release to both the YMCA and releases from claim or liability related to that use; waiving all claims for myself, my household, my child and any heirs or next of kin. IF I CHOOSE NOT TO BE PHOTOGRAPHED OR IN OTHER RECORDED MEDIA, IT IS MY RESPONSIBILITY TO INFORM THE PHOTOGRAPHER AND/OR REMOVE MYSELF FROM THE PICTURE.

_____ _____
Initials Date

ACKNOWLEDGEMENT OF RISK AND RELEASE FROM LIABILITY

THE UNDERSIGNED PERSON hereby acknowledges intent to participate with the YMCA of Indiana County activities. The undersigned freely and unconditionally waives and releases the YMCA and any and all of its employees, representatives volunteers, and agents and their successors and assigns (the "YMCA of Indiana County") from all liability and/or claims of the Undersigned, his personal representatives, and/or his estate for any and all loss or damage and/or claims of demands due to: personal injury as result of my physical condition; slip trip or fall; aquatic injuries; athletic injuries; and illness, including exposure to and infection with viruses or bacteria resulting from my participation in any activities, YMCA programs led by staff or volunteers, and the use of any equipment, exercise or other activities. The Undersigned further agrees to defend, indemnify and hold the YMCA harmless from and against any and all liabilities, demands, claims, damages, suits, judgments and decrees, and court awards including costs, expenses and attorneys' fees, on account of injuries to or death of any person or persons or damage to any property arising out of or related to the Volunteer's intentional or negligent acts, errors or omissions now or in the future.

CORONAVIRUS/COVID-19 WARNING & DISCLAIMER

Coronavirus, COVID-19 is an extremely contagious virus that spreads easily through person-to-person contact. Federal and state authorities recommend social distancing as a means to prevent the spread of the virus. COVID-19 can lead to severe illness, personal injury, permanent disability, and death. Participating in YMCA of Indiana County programs or accessing their owned and operated facilities could increase the risk of contracting COVID-19. The YMCA of Indiana County in no way warrants that COVID-19 infection will not occur through participation in programs or accessing their facilities.

I understand that the YMCA of Indiana County is not responsible for personal property lost or stolen while members and/or program participants are using YMCA facilities or on YMCA premises.

I HAVE CAREFULLY READ THE FOREGOING WAIVER, UNDERSTAND ITS CONTENTS, AND AM AWARE THAT I AM RELEASING CERTAIN LEGAL RIGHTS. I ACKNOWLEDGE THAT I AM SOLELY RESPONSIBLE FOR ANY INJURIES INCURRED WHILE PARTICIPATING WITH THE YMCA.

I certify that the information contained in this application is true and correct to the best of my knowledge. I have read the waiver agreement, understand it's content, and acknowledge that I am responsible for any injuries encountered while participating, except for those caused by the negligence of the YMCA of Indiana County.

I understand that I and all the individuals in my membership unit can find all the membership policies and agreements, including the code of conduct, in the Member Handbook. I can request a printed copy of this handbook at any time at the Welcome Center. I understand that by signing this form I will adhere to all policies set in the above listed forms.

_____ _____ _____ _____
Name Date of Birth Spouse's Name Date of Birth

_____ _____ _____ _____
Address City State Zip

_____ _____
Primary Phone E-mail

_____ _____ _____ _____
Signature of Participant or Parent/Guardian Date Spouse's Signature Date

Please indicate the children that you wish to be covered with this waiver:

_____ _____ _____ _____
Name Date of Birth Name Date of Birth

_____ _____ _____ _____
Name Date of Birth Name Date of Birth

_____ _____
Emergency Contact Name Phone Number

Office Use Only:

D.L. #: _____ _____ _____
MSR Witness Initial Date

Handbook Sign off Sheet

I understand the importance of maintaining a positive, healthy relationship with the Y. This includes working collaboratively with my child's teacher, Director and extended staff.

I understand the importance of meeting my child's payment schedule and that I will be placed on automatic billing. If accounting needs to continually dedicate additional time in securing my payment, I place my child's enrollment at risk.

I understand teachers cannot properly care for my sick child without interfering with the care of the other children. If my child/children demonstrate physical signs of illness, I will be notified for immediate pick-up. I further understand I have a maximum time frame of one hour to pick-up my child; otherwise my emergency contact will be contacted. If my child exhibits any signs of contagious disease, I will be asked to provide a medical evaluation.

I understand that my child's care falls within a classroom setting; set by state ratios. If my child needs greater attention than the ratio can support, or displays harm to self or others, my Director will schedule a parent/teacher conference to discuss an action plan of care with me.

I understand that the guidelines of this handbook may change at any time. When they do, I will be alerted by the Director and the website will always host the most up to date version of this handbook.

_____

Child Printed Name

_____

Guardian Printed Name

_____ _____

Guardian Signature Date

CACFP Meal Benefit Income Eligibility Form
Letter to Parents (Non-Pricing Centers)
July 1, 2023-June 30, 2024

July 28, 2023

Dear Parent or Guardian**:**

YMCA of Indiana County offers healthy meals and snacks to children as part of the Child and Adult Care Food Program (CACFP). **YMCA of Indiana County** receives support from CACFP to serve those meals. CACFP gives more support if your household income is less than or equal to the limits on this chart:

Federal Income Standards for Reduced-Price Meals for July 1, 2023 - June 30, 2024		
Household size	Yearly Income	Monthly Income
1	$26,973	$2,248
2	$36,482	$3,041
3	$45,991	$3,833
4	$55,500	$4,625
5	$65,009	$5,418

Please fill out a *CACFP Meal Benefit Income Eligibility* form. It will help us find out how much support **the YMCA of Indiana County** receives. Please be sure to read the instructions carefully. Fill in all the information we request. We can only accept complete forms. Please send the completed form to:

YMCA of Indiana County 60 N. Ben Franklin Rd. Indiana PA 15701

Thank you for taking the time to fill out the form. We hope your child enjoys CACFP meals!

In the operation of child nutrition programs, no person will be discriminated against because of race, color, national origin, sex, age, or disability. If you have questions or need help, please contact **Barb Thornton** at **724-463-9622** or **barbthornton@icymca.org**.

Sincerely,

Signature

Barb Thornton
Director of Youth and Family Programs

CACFP Meal Benefit Income Eligibility Form Instructions
July 1, 2023-June 30, 2024

The Child and Adult Care Food Program (CACFP) makes good food a regular part of your child's day care! Please fill out the *CACFP Meal Benefit Income Eligibility* form. It helps us find out if your household qualifies for free or reduced-price meals. This lets us know how much money CACFP will give to support your day care home or center.

Instructions

Here are instructions to help you fill out the form. Before you begin, turn the form over to learn why we ask for this information. It tells you how we use the information and what rights you have. It also tells you how to contact USDA if you believe you are treated unfairly.

Please make sure to fill in all of the requested information. Use a pen to mark your answers on one form. When you are finished, please return the form to us at:

YMCA of Indiana County 60 N. Ben Franklin Rd. Indiana, PA 15701.

Step 1:

List all the children from your household in the day care. Use one line for each child's name. Write one letter in each box. Stop if you run out of space. If there are more children, add their names on a second piece of paper.

Do you have any foster children? If you answer *Yes*, mark the *Foster Child* box next to the child's name. If you are only applying for foster children, finish Step 1 and go to Step 4. If you are applying for both foster and non-foster children, go to Step 2.

Are any children migrant, runaway, homeless, or enrolled in Head Start? If *Yes,* mark the correct boxes next to the child's name and go to Step 4.

Step 2:

You qualify for free meals if you live in a household that receives Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR).

Do any household members, including you, currently receive SNAP, TANF, or FDPIR? If *Yes*, write the case number in the box and go to Step 4. You only need to provide one case number. If *No*, go to Step 3.

Step 3:

Report current income for all household members. Skip this step if you answered Yes in Step 2.

How do you report child income? Turn the form over and use the *Source of Income for Children* chart to see if your household has income to report. Write the amount in the boxes in part A of the form. Mark how often the amount is earned. Write *0* in the box if there is no income to report.

How do you report the income of adult household members? Turn the form over and use the *Source of Income for Adults* chart to see if your household has income to report.

In part B, list all the adults in your household, including you, even if each of you doesn't receive income. Include all adults, such as grandparents, other relatives, and friends who live with you and share household income and expenses. Write the amount of income each of you receives, in the boxes next to your names. Mark how often the amount is received. Write *0* in the box if there is no income to report.

Make sure you report the current amount of money you get before taxes. Don't include SNAP, FDPIR, WIC, student financial aid, or money you receive for a foster child as income.

Count the number of all children and adults in your household. Include all infants, children, students, and adults. Write the total number in the box under the list of adult household members.

Do you or another adult household member have a Social Security number? Write the last four digits in the boxes. If there is no Social Security number, mark the *Check if no SSN* box.

Points to Remember:

If:	Then:
Your income isn't always the same	List the amount of money that you normally get. For example, don't include overtime pay, if you don't normally get it. If your income is normally higher or lower, you can report annual income instead.
Your household includes members who aren't citizens	You or your children don't have to be U.S. citizens to qualify for meal benefits.
You are in the military	Don't include your Family Subsistence Supplemental Allowance (FSSA), combat pay, or the money you receive for privatized housing. If deployed, count the amount of pay that is made available to your household as income.

Step 4:

An adult household member must sign this form. The signer promises that all information is true and complete.

Print the name, address, and telephone or email of the adult signer. Sign and write today's date in the marked boxes.

Optional

We ask about your children's ethnicity and race to make sure we do our best to serve our community. Providing this information is not required. You won't be denied benefits based on your race, color, national origin, sex, age, or disability.

CACFP Meal Benefit Income Eligibility Form
Sharing Information with Medicaid and SCHIP
July 1, 2023-June 30, 2024

Children who get Child and Adult Care Food Program (CACFP) free or reduced-price meals may also qualify for low cost health insurance through Medicaid or the State Children's Health Insurance Program (SCHIP).

We may share your child's CACFP eligibility information with Medicaid or SCHIP, *unless you tell us not to*. Medicaid and SCHIP *only* use the information to find out if children are eligible for their programs. Their staff may contact you to offer to enroll your children in these health insurance programs.

If you **do not** want us to share your information with Medicaid or SCHIP, fill out this page. You should send this page with your *CACFP Meal Benefit Income Eligibility* form when you apply. Sending in this page will not change your child's eligibility for free or reduced-price meals.

☐ **No! I do not** want my child's CACFP eligibility information shared with Medicaid or SCHIP.

If you checked no, fill this out:

Child's Name:
_____

Child's Name:
_____

Child's Name:
_____

Child's Name:
_____

Today's Date:
_____

Print Your Name:
_____

Address:
_____

Signature of Parent or Guardian:
_____

If you have questions or need help, please contact **Barb Thornton** at **724-463-9622** or **barbthornton@icymca.org**.

This institution is an equal opportunity provider.

CACFP Meal Benefit Income Eligibility (Child Care)

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

STEP 1 List ALL children in day care (if more spaces are required for additional names, attach another sheet of paper)

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related."

Children in Foster care and children who meet the definition of **Homeless, Migrant** or **Runaway** are eligible for free meals.

Child's First Name	MI	Child's Last Name	Foster Child	Migrant	Runaway	Homeless	Head Start
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐

Check all that apply

STEP 2 Do any household members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR?

IF NO > Go to STEP 3 **IF YES >** Write case number here and proceed to STEP 4 (do not complete STEP 3)

CASE NUMBER:

Write only one case number in this space.

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

The **"Sources of Income for Children"** chart will help you with the Child Income section.

The **"Sources of Income for Adults"** chart will help you with All Adult Household Members section.

A. Child Income

Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Children listed in STEP 1 here.

Child Income	How often? Weekly	Bi-Weekly	Monthly	Bi-Monthly
$	○	○	○	○

B. All Household Members (Including yourself)

List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Household Members (First and last)	Earnings from Work	How often? Weekly	Bi-Weekly	Monthly	2x Month	Welfare/Child Support/Alimony	How often? Weekly	Bi-Weekly	Monthly	2x Month	Pensions/Retirement/ Social Security/SSI/ VA Benefits	How often? Weekly	Bi-Weekly	Monthly	2x Month
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○

Total Household Members (Children and Adults)

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or other Adult Household Member X X X X X

Check if no SSN ☐

STEP 4 Contact information and adult signature. This form is not valid without signature and date of adult household member

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Print Name of Adult Signing the Form

Signature of Adult

Today's Date

Address

City

State

Zip

Phone/Email

Source of Income for Children	
Sources of Child Income	**Examples**
Earnings from work	• A child has a regular full or part-time job where they earn a salary or wages
Social Security - Disability Payments - Survivors Benefits	• A child is blind or disabled and receives Social Security benefits • A parent is disabled, retired, or deceased, and their child receives Social Security benefits
Income from person outside of household	• A friend or extended family member reguarly gives a child spending money
Income from any other source	• A child receives regular income from a private pension fund, annuity, or trust

Source of Income for Adults		
Earnings from Work	**Public Assistance/Alimony/ Child Support**	**Pensions/Retirement/ All other sources of income**
• Salary, wages, cash bonuses • Net income from self-employment (farm or business) **If you are in the U.S. Military:** • Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) • Allowances for off-base housing, food, and clothing	• Unemployment benefits • Workers compensation • Supplemental Security Income (SSI) • Cash assistance from State or local government • Alimony payments • Child support payments • Veterans benefits • Strike benefits	• Social Security (including railroad retirement and black lung benefits) • Private Pensions or disability benefits • Income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • Regular cash payments from outside household

OPTIONAL Children's Ethnic and Racial Identities (Optional)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

MAIL*: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

FAX: (202) 690-7442; or
EMAIL: program.intake@usda.gov.

This institution is an equal opportunity provider.

***Only use this address if you are filing a complaint of discrimination.**

For Official CACFP Sponsor Use Only NOT VALID WITHOUT DETERMINING OFFICIAL'S SIGNATURE AND DATE

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

Total Income

How often? Weekly ○ Bi-Weekly ○ Monthly ○ 2x Month ○

Household size

Categorial Eligibility ☐

Eligibility: Free ○ Reduced ○ Denied ○

Determining Official's Signature

Date

Confirming Official's Signature (second check)

Date

Follow-up Official's Signature (For Pricing Institutions - Verification Official)

Date

Effective Date: If the Institution is using the parent/guardian signature date as the effective date, the form must have been signed by the Institution representative within the same month the parent signed the form or the immediately following month.

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 BIRT	ADDRESS:
CHILD CARE FACILITY NAME: YMCA OF INDIANA COUNTY	
FACILITY PHONE: COUNTY:	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.

UARDIAN'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)

☐ 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:

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