MCLB Albany
Child Development Center
Enrollment Packet

****Eligibility & Enrollment Statement per Marine Corps Order P1700.27A**

"Eligible users shall include military personnel, DoD civilian personnel, active duty coast guard, reservist on active duty or during inactive duty for training, and D0D contract personnel who are performing mission related duty on installation. Retirees may be eligible when a waiting list does not exist and when space is available."

****The following enrollment packet will ask information about the Sponsor. The Sponsor is the eligible member described above. Sponsors must be the parent or legal guardian of the child they are enrolling.**

Did you attach the following forms to the completed enrollment packet?

- ___ **Current Immunization Record (*GA Form 3231*)**
- ___ **Health Assessment (*signed by physician*)**
- ___ **LES or Check stubs for your household (*not required for drop-in care*)**
- ___ **Family Care Plan (*Single or Dual Active Duty only*)**
- ___ **Copy of CAC card or Military ID**

Fill out all forms completely and return to:
Becky Shiver
Supplemental Programs,
Resource & Referral Manager
814 Radford Blvd, Suite 20311
Building 7600
Albany, GA 31704-0311
229-639-7930 DSN 567-7930
Fax: 229-639-6157

MCLB ALBANY CHILDREN, YOUTH & TEEN PROGRAMS

REGISTRATION FORM

ENROLLMENT DATE: ____________ **BRANCH OF SERVICE**: _________

CHILD'S NAME: ____ **DOB**:______________

ETHNICITY: ____________ **M or F** (Please Circle)

SPONSOR'S NAME: ____ **RANK/RATE**: _____________

ADDRESS: ____ HOUSING LOCATION

CITY, STATE: _________________________ ZIP:_____________________ ON BASE____ OFF BASE____

SSN:_____________________ **DOB**: _______________ **HOME PHONE**: _____________

UNIT/WORKSTATION: ____ **WORK PHONE**: _____________

EMAIL ADDRESS: ____ **CELL PHONE**: ______________

SPOUSE'S NAME: ____ **RANK/RATE**: _______________

SPOUSE'S WORK/OTHER INFO: ___________________________________ **WORK PHONE**: _____________

EMAIL ADDRESS: ____ **CELL PHONE**: ______________

IN THE EVENT I CANNOT PICK UP MY CHILD FOR ANY REASON OR IN CASE OF EMERGENCY, I HEREBY AUTHORIZE THE FOLLOWING PERSON(S) TO PICK UP MY CHILD OR BE CONTACTED FOR EMERGENCIES:

(1)____

(NAME) (RELATION TO CHILD) (CONTACT NUMBER)

(2)____

(NAME) (RELATION TO CHILD) (CONTACT NUMBER)

(3)____

(NAME) (RELATION TO CHILD) (CONTACT NUMBER)

FOR OFFICE USE ONLY

FT, PT, DI, BF, AFT, CAMP, YTC Teacher __________________________ Rcvd By_________________

AD, CIV, CTR, RESRV, RET

_____ Parent Handbook _____CYMS _____FCP needed R&R ____________

_____Orientation _____SNERT needed _____Pre-K

MCLB ALBANY
CHILD DEVELOPMENT CENTER FEE SCHEDULE
DUE 1ST AND 15TH OF EACH MONTH

Total Household Income*	Full-Time (Over 20 hrs/wk)	Full-Time Multi-Child Discount	Part-Time (Up to 20 hrs/wk)	Part-Time Multi-Child Discount	Drop-In (Up to 9 hrs/wk)	Annual Registration Per child
Level 1 $0- $29,400	$113.00	$102.00	$66.00	$59.00	$3.00/hour Per child	$ 24.00
Level 2 $29,401- $35,700	$139.00	$125.00	$81.00	$73.00	$3.00/hour Per child	$24.00
Level 3 $35,701- $46,200	$167.00	$150.00	$97.00	$87.00	$3.00/hour Per child	$24.00
Level 4 $46,201- $57,750	$202.00	$182.00	$117.00	$105.00	$3.00/hour Per child	$24.00
Level 5 $57,751- $73,500	$234.00	$211.00	$136.00	$122.00	$3.00/hour Per child	$24.00
Level 6 $73,501- $85,000	$269.00	$242.00	$156.00	$140.00	$3.00/hour Per child	$24.00
Level 7 $85,001- $100,000	$288.00	$259.00	$167.00	$150.00	$3.00/hour Per child	$24.00
Level 8 $100,001- $125,000	$295.00	$266.00	$171.00	$154.00	$3.00/hour Per child	$24.00
Level 9 $125,001 +	$301.00	$271.00	$175.00	$158.00	$3.00/hour Per child	$24.00

*Gross income (before taxes), includes BAH and BAS.

Before and After School Fees
(Applied during the school year only)

Household Income Level	Before School Only	After School Only	Both Before & After School	School Age Drop-In (up to 9 hrs a week)
Level 1	$11.00	$23.00	$38.00	$3.00/ hr per child
Level 2	$16.00	$28.00	$52.00	$3.00/hr per child
Level 3	$20.00	$34.00	$64.00	$3.00/hr per child
Level 4	$29.00	$40.00	$78.00	$3.00/hr per child
Level 5	$33.00	$48.00	$90.00	$3.00/hr per child
Level 6	$38.00	$54.00	$104.00	$3.00/hr per child
Level 7	$42.00	$58.00	$112.00	$3.00/hr per child
Level 8	$46.00	$60.00	$114.00	$3.00/hr per child
Level 9	$50.00	$62.00	$116.00	$3.00/hr per child

Revised 9/2011

PRIVACY ACT STATEMENT

AUTHORITY: 5 U.S.C. Sec 301

The information, which will be solicited, is intended principally for the following purposes:

a. Determination of those dependents eligible to be placed in the Child Development Center or Youth Teen Center maintained by the Marine Corps Logistics Base, Albany, Georgia.
b. To provide information to the CDC or YTC personnel on any health problem of your child, youth or teen and to have necessary information on file to contact parents in case of emergency.
c. Other determinations, as required, in the course of naval administrations.

ROUTINE USE: In addition to being used within the Department of the Navy and Defense for the purpose(s) indicated above, the record may, as appropriate, be furnished to the U.S. Attorney for use in determinations concerning issues of liability.

DISCLOSURE: Disclosure of requested information is voluntary. However, if requested information is not provided, individuals will not be allowed to utilize the CDC or Youth Teen Center.

Health Data

Does your child have any Allergies (food or other)? Please List: ________________________________

(Regarding allergies, documentation on the Health Assessment form or note from child's Physician is required. Also note that this information will be posted in classrooms.)

Any other Medical Conditions (Asthma, etc)____

____

____

Child's Doctor/Pediatrician:

Name:_________________________________ Phone Number: ____________________________

Hospital preferred: ____

A special need is defined as a condition requiring special medical, medically-related, or special education services. Special needs include those characterized as physical, intellectual, emotional, or psychological. Every effort will be made to provide care for children with special needs. No child who meets the basic age and eligibility requirements may, solely on the basis of disability, be excluded from programs when reasonable accommodations can be made to meet their needs. Any child with special needs requesting care will need to provide documentation of current diagnosis and treatment. A Special Needs Evaluation Review Team will meet prior to enrollment to determine the best accommodations in the least restrictive environment. These meetings are designed to create a Family Service Plan, which will detail the care necessary to provide a safe and developmentally appropriate environment for the child with a special need.

Please list your child's special need (if applicable)____

If you listed an allergy, medical condition or special need, please make sure to provide this information on the Health Assessment or provide a doctor's note regarding your child's needs ie: diet restrictions, medications, diagnosis, or special equipment needed.

We **do not** have a registered nurse on site. All staff are trained in first aid and our emergency response is to call 911, base personnel will respond. It is our policy to immediately contact the parent(s) or guardian following any injury or asthma attack.

Child and Family Questionnaire

Parents,

The following questions will be used to help us learn more about your child so that we can plan for his or her development. All of the information will be kept confidential and will be used only by your child's teachers and/or the Training and Curriculum Specialist.

Child's Name___________________________ Nickname________________________

Date of Birth___________________________ Place of Birth_____________________

What languages, other than English, are spoken in your family's home?

Is your child toilet trained?

What are some things that you enjoy doing as a family?

What holidays are celebrated by your family?

Does your child take regular naps at home?

Does your child speak well enough to be understood by others?

Does your child have any special fears?

What do you hope your child will learn while in our program?

Which of these best describes your child?

__Lack of self control	or	__uses self control
__Independent	or	__dependent
__Pleasant	or	__disagreeable
__Attentive	or	__inattentive
__Confident	or	__shy

CDC Operations Guidelines & Service Contract

1. The fee plan for the CDC is prescribed by the DoD. A current fee schedule is available at the CDC.
2. **Payments**- All CDC payments are made in advance and are **due on the 1st and 15th of each month** (if these dates fall on weekends or federal holidays, payment is due the next business day). Full time care is defined as contracted weekly usage of CDC services for 21-50 hours per week per child. Part-time care is defined as contracted weekly usage of CDC services for 10-20 hours per week per child. Drop-in/Hourly care is defined as usage of the CDC for 9 or less hours per week. If a child is enrolled during the pay period, the charges will be prorated for the remainder of the days in that one payment period. If a child is in care over the amount covered in their contract, they will be charged the fee of the higher Time care. For example, if a contract is for Drop-in but the child is in care for 12 hours then the patron is charged at the Part-time rate.
3. To reduce administrative costs, parents must notify the CDC Director one to two weeks in advance of anticipated leave (vacations, personal days, illness, etc.). Payment is still required during absences.
4. An annual, non-refundable **$24.00 Registration Fee** per child is required for CDC Services. This fee will be paid at the time of registration and on the anniversary date of enrollment each year.
5. **Removing your child from the program**- Two weeks written notification is required for disenrollment or regular fees will be assessed.
6. **Late Pick-Up Fees**- the CDC closes promptly at 6:00 pm. Children at the CDC after 6:00 pm will be charged $5.00 for each additional minute. After the first 5 minutes late, patrons will be charged $5.00 for each additional minute. Please be sure that all children are picked up by 6:00 pm.

Contract for Services

I, the parent or legal guardian of ______________________________, contract full-time, part-time or drop-in care services from the MCLB Child Development Center (CDC). I will be contracting the use of care during the following hours:

Monday	_______________	to	________________
Tuesday	_______________	to	________________
Wednesday	_______________	to	________________
Thursday	_______________	to	________________
Friday	_______________	to	________________

Late Payment Charges – there will be a $6.00 per day late charge for payments made after the due date. If the balance due, including late fees, is not paid in full 5 working days after the payment due date your child care services will be terminated effective immediately on the 5th day of non-payment. If you wish to re-enroll your child, you must pay in full any delinquent accounts, complete the appropriate paperwork and pay the registration fee at the Children, Youth & Teen Programs Office.

I have read and fully comprehend the above Operations Guidelines and Service Contract concerning my obligations to the CDC.

____ ____

Sponsor's Signature ***Date*** ***Spouse's Signature*** ***Date***

DEPARTMENT OF DEFENSE CHILD DEVELOPMENT PROGRAM
REQUEST FOR CARE RECORD

PRIVACY ACT STATEMENT

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

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

ROUTINE USE(S): None.

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

1. DATE OF REQUEST *(YYYYMMDD)*	2. EXPIRATION DATE *(YYYYMMDD)*	
3. FAMILY INFORMATION		
a. SPONSOR'S NAME *(Last, First, Middle Initial)*	b. SPOUSE'S NAME *(Last, First, Middle Initial)*	
c. CHILD'S NAME *(Last, First, Middle Initial)*	d. CHILD'S DATE OF BIRTH *(YYYYMMDD)*	e. CHILD'S AGE
f. HOME ADDRESS *(Street, City, State, Zip Code)*	g. SPONSOR'S BRANCH OF SERVICE h. DUTY ORGANIZATION	
i. HOME TELEPHONE NUMBER *(Include Area Code)*	j. DUTY TELEPHONE NUMBER *(Include Area Code)*	

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

(1) NAME *(Last, First, Middle Initial)*	(2) DATE OF BIRTH *(YYYYMMDD)*	(1) NAME *(Last, First, Middle Initial)*	(2) DATE OF BIRTH *(YYYYMMDD)*

4. PROGRAM(S) DESIRED *(X as applicable)*				**5. AGE GROUP** *(X one)*	
	a. FULL-DAY CARE		e. FAMILY DAY CARE (FDC)		a. INFANTS *(0 - 12 months)*
	b. PART-DAY CARE		f. PART-DAY ENRICHMENT		b. TODDLERS *(13 - 35 months)*
	c. SCHOOL-AGE		g. DAY CAMP		c. PRESCHOOL *(3 - 5 years)*
	d. SPECIAL NEEDS				d. SCHOOL AGE *(5+ years)*

6. SPONSOR STATUS *(X one)*

	a. SINGLE MILITARY		e. SINGLE DOD CIVILIAN		i. MILITARY/UNEMPLOYED SPOUSE
	b. DUAL MILITARY		f. RETIRED MILITARY		j. MILITARY/OTHER THAN DOD SPOUSE
	c. MILITARY/DOD SPOUSE		g. MILITARY RESERVE		k. OTHER *(Specify)*
	d. DUAL DOD CIVILIANS		h. NATIONAL GUARD		

7. PRESENT CHILD CARE ARRANGEMENTS *(X as applicable)*

	a. FDC ON-INSTALLATION		d. CIVILIAN CDC		g. IN-HOME CARE
	b. FDC OFF-INSTALLATION		e. MILITARY ALTERNATE CARE		h. NO PRESENT CARE
	c. OTHER MILITARY CHILD DEVELOPMENT CENTER (CDC)		f. NON-MILITARY ALTERNATE CARE		i. OTHER *(Specify)*

8. GENERAL INFORMATION *(X and complete as applicable)*

YES	NO		YES	NO	
		a. IF CHILD IS NOT PRESENTLY IN CARE, IS EMPLOYMENT OF SPOUSE AWAITED? *(If Yes, estimate average annual Income lost)*			c. IS CHILD ON OTHER MILITARY WAITING LIST? *(If Yes, name installation)*
		b. HAS CHILD BEEN IDENTIFIED FOR SPECIAL NEEDS CARE?			d. CURRENT COST OF CARE PER WEEK *(If child is currently in care)*

9. UPDATE REQUIRED PER INSTRUCTIONS *(For Office Use Only)*

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

APPLICATION FOR DEPARTMENT OF DEFENSE CHILD CARE FEES

PRIVACY ACT STATEMENT

AUTHORITY: Public Law 101-189, Section 1504; E.O. 9397.

PRINCIPAL PURPOSE(S): To collect total family income data to determine child care fees.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary; however, failure to furnish information will result in placement in the highest fee range.

SECTION I - DEPENDENT CHILDREN

To determine child care fees for your child(ren), or any child(ren) you legally claim as your dependent(s), you must complete, sign, and return this form to the director of the program you are applying for. Fees will be determined based on your total family income as defined below. If you do not wish to disclose your total family income, your rate will be set automatically at the highest fee level.

1. NAME OF EACH CHILD *(LAST, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. AGE	4. CARE REQUESTED
a.			
b.			
c.			
d.			
e.			

SECTION II - ANNUAL FAMILY INCOME *(To be completed by sponsor. Include all military and civilian earned income for sponsor and spouse.)*

Enter your annual income data as requested; e.g., multiply the most recent monthly income by 12 or if paid on a biweekly income, enter the most recent biweekly income and multiply by 26. For purpose of determining child care fees in DoD Child Care program, total family income is defined as all earned income including wages, salaries, tips, long-term disability benefits, combat pay and voluntary salary deferrals. Include all earned income such as wages, salaries, tips, long-term disability benefits, voluntary salary deferrals, retirement or other pension income, etc., before deductions for taxes, social security, etc. Include quarters subsistence and other allowances appropriate for the rank and status of military or civilian personnel whether received in cash or in kind. For dual military living in government quarters include BAH-II of senior member only. Include anything else of value, even if not taxable, that was received for providing services. DO NOT INCLUDE cost of living allowance (COLA) received in high cost areas, alimony and child support, temporary duty allowances or reimbursements for educational expenses.

5. SPONSOR

a. NAME *(LAST, First, Middle Initial)*	b. SSN	c. YEARS OF MILITARY/CIVIL SERVICE

d. INCOME

(1) BASE PAY *(Most recent leave and earnings statement)*	(2) BASIC ALLOWANCE FOR HOUSING *(Or in-kind equivalent) (Annual chart of minimum BAH-II)*	(3) BASIC SUBSISTENCE ALLOWANCE *(Or in-kind equivalent)*	(4) OTHER EARNED INCOME AS DESCRIBED ABOVE

6. SPOUSE

a. NAME *(LAST, First, Middle Initial)*	b. SSN	c. YEARS OF MILITARY/CIVIL SERVICE

d. INCOME

7. OTHER EARNED INCOME AS DESCRIBED ABOVE	8. TOTAL INCOME FOR SPONSOR, SPOUSE, AND OTHER

SECTION III - CERTIFICATION OF SPONSOR *(Required for Category I - IV. Please read the following statement carefully before signing.)*

I certify that all of the above information is true and correct and that all family income of the spouse and sponsor is reported. I understand that this information is being given in order to determine child care fees to be paid and that Federal funds are used to subsidize the cost of child care. I also understand that the installation commander may verify the information on the application; and that deliberate misrepresenta- tion of this information may subject me to prosecution under applicable State and Federal laws. See 18 U.S.C. Section 1001.

9. SIGNATURE OF SPONSOR*	10. SIGNATURE OF SPOUSE	11. DATE SIGNED *(YYYYMMDD)*

**If signature is missing, the fees will automatically be placed at the highest level.*

12. TELEPHONE NUMBERS *(Include Area Code)*		13. HOME ADDRESS *(List apartment number and 9-digit ZIP Code)*
a. HOME	b. WORK	
(1) SPONSOR		
(2) SPOUSE		

SECTION IV - FOR CHILD DEVELOPMENT CENTER USE ONLY

14. CATEGORY OF APPROVAL	15. AUTHORIZED FEES
16. DATE OF APPROVAL *(YYYYMMDD)*	17. NAME OF CHILD DEVELOPMENT PROGRAM OFFICIAL

 PREVIOUS EDITION IS OBSOLETE.

Reset

Children, Youth, and Teen Programs (CYTP) Parent/Guardian Permissions

I, ____

the parent(s)/guardian(s) of : ____

____

understand and authorize certified and designated CYTP representative(s) to:

- take my child/children for medical treatment in case of an emergency where the child's condition poses an imminent or reasonably foreseeable threat to his/her loss of life, serious bodily injury, or other permanent or long term serious health risk. Additionally, it may be necessary for emergency medical personnel to transport my child/children to the best available medical facility in the vicinity.

- take all reasonable efforts to immediately notify me, and as circumstances permit, prior to taking any of the above actions. My points of contact and its indicated preferred order, are listed as follows (circle or line through the applicable or non-applicable information):

    1. (Work / Mobile / Home): ________________________________ ;

    2. (Work / Mobile / Home): ________________________________ ;

    3. (Work / Mobile / Home): ________________________________ ;

Please Note: For School Age Children and Teens Only: The Youth and Teen Programs have access to computers and the Internet. In order for your Youth or Teen to use the computers and the Internet, by signing below the parent(s)/guardian(s) grant permission for this access. The Youth and Teen programs personnel will monitor and block access to inappropriate sites, to include by way of the network firewalls and related content filters. Nonetheless, inherent with such computer use is the risk that some inappropriate internet sites may be temporarily accessed. All reasonable efforts will be made to prevent and mitigate any infractions.

Use of photographs/video for release to media. Yes ☐ No ☐

Field trip/Walk Yes ☐ No ☐

____

Parent(s)/Guardian(s) Signature Date

TOUCH POLICY

Policy: This Children & Youth Programs touch policy is based on the premise that positive physical contact with children is absolutely necessary for their guidance: whereas, "no touch" under any circumstances, creates a stark and unacceptable atmosphere for young children. Based on this premise, individuals involved in direct care will provide positive physical contact (appropriate contact) and refrain from inappropriate touch. Children will always have the option to refuse touch except in the case of danger to other children or to themselves.

CLARIFICATION OF TERMS

1. **Appropriate** touch involves:
    a. Recognition of the importance of physical contact to child nurturance and guidance.
    b. Adult respect for personal privacy and personal space of children.
    c. Having the permission of the other for touch.
    d. Responses affecting the safety and well being of the child.
    e. Role modeling of appropriate touch by direct care staff.
2. Examples of **appropriate** touch are:
    a. Hugs, holding hands and lap sitting as expressions of affection to build self-esteem or when the child needs to be comforted.
    b. Reassuring touch on the shoulder to show approval or provide support.
    c. Naptime back rubs to relax a tense child.
    d. Diapering of infants and toddlers.
    e. Assistance in toileting for children when needed.
3. **Inappropriate** touch may involve any or all of the following:
    a. Coercion (physical or emotional) or other forms of exploitation of the child's lack of knowledge.
    b. Disregard for safety and well being of the child.
    c. Failure to respect the child's right to personal privacy and space or to refuse touch from an adult.
    d. Satisfaction of adult needs at the expense of the child.
    e. Violates a cultural taboo against sexual contact between adults and children.
    f. Attempts to change child behavior with adult physical force, often applied in anger.
    g. Reinforces with children the concept of "striking out" to solve a problem.
4. Examples of **inappropriate** touch are:
    a. Forceful holding of a child in a chair or squeezing a child's hand with sufficient force to cause pain as a way to change behavior.
    b. Forced goodbye kisses.
    c. Corporal punishment (spanking).
    d. Sexual exploitation (fondling or molestation).
    e. Hitting or in any way physically assaulting a child.
    f. Prolonged tickling.
5. Responsibilities:
    a. CDC Director and FCC Director will:
        1. Monitor Children, Youth and Teen Programs for compliance with the touch policy.
        2. Ensure that the Children, Youth and Teen Programs touch policy is discussed during the orientation phase for all new staff members, registered providers and volunteers and that the new staff, providers and volunteers sign a statement of understanding.
        3. Take immediate disciplinary action for infractions of the touch policy.
        4. Ensure parents are aware of the policy.
        5. Sign a statement of understanding indicating they have read and understand the Children, Youth and Teen Program policy and the consequences of failure to comply.
        6. Report to their supervisor any instances of inappropriate touch of which they are aware.

____

Signature   Date

CHILDREN AND YOUTH PROGRAMS DISCIPLINE POLICY STATEMENT

1. Only managers, direct care staff, or teachers may discipline children. The discipline policy of Children, Youth and Teen Programs is designed to help the child develop self-control, self-esteem, and a respect for the rights of others. In all cases, discipline will give positive guidance, allow for redirection, and set clear behavior limits.

2. In no case will any humiliating or frightening punishment be used to discipline a child. Such unacceptable punishments as those listed below will not be used and are expressly forbidden:

   a. Spanking, slapping, hitting, pinching, shaking, or giving any form of physical punishment.

   b. Verbal abuse, threats, derogatory remarks about a child or the child's family, or any form or derivative of profanity used toward a child or in child's presence.

   c. Binding, trying to restrict movement, or placing in a confined space such as a closet, locked room, or similar space.

   d. Withholding or forcing meals, snacks, or naps.

   e. Children will not be punished for lapses in toilet training.

3. Only acceptable guidance techniques will be utilized in disciplining children to include talking with the child, temporarily removing the child from stressful situations and limiting the child's participation in certain activities. Children whose behavior cannot be corrected by these acceptable techniques should be instructed that his or her parent is a being called to the center. In the case of repeated incorrigible behavior; a child could be restricted from the use of the Child Development facility. Documentation of such incorrigible behavior, as well as any notification to the parents, is essential.

4. Children, Youth and Teen Program personnel will not exceed these acceptable techniques. To do so could result in the termination of their employment. Children, Youth and Teen Program personnel will be constantly mindful of the Marine Corps policies and Base policies concerning child abuse and will report all instances of suspected abuse, molestation, or neglect to the Child Development Center Director, Marine Corps Family Team Building Director or Marine and Family Services Family Advocacy Program Manager.

____

Signature Date

Due Within 30 days of Enrollment & Annually Thereafter. **Due Date:**

CHILDREN, YOUTH AND TEEN PROGRAMS

HEALTH ASSESSMENT

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY:	Title10, United States Code, Section 3012
PRINCIPAL PURPOSE:	Information is used by DoD personnel to: (1) verify child/youth/teen health status per admission requirements: (2) note special program considerations or restrictions on child/youth/teen participation; (3) execute emergency medical procedures for chronic illness/conditions; (4) refer child/youth/teen for enrollment in Exceptional Family Member Program.
ROUTINE USES:	No information is disclosed outside DoD.
DISCLOSURE:	Disclosure of requested information is voluntary; however, if information is not provided, individuals may not be able to participate in Children, Youth & Teen Programs.

NAME/RANK OF SPONSOR: TELEPHONE (HOME) TELEPHONE (DUTY)

NAME OF CHILD/YOUTH/TEEN DATE OF BIRTH SEX (circle one)

M **F**

HAS CHILD/YOUTH/TEEN BEEN UNDER REGULAR SUPERVISION OF A PHYSICIAN? (If yes, explain circumstances and current status)
☐ YES ☐ NO

HAS CHILD/YOUTH/TEEN BEEN SCREENED FOR ENROLLMENT IN THE EXCEPTIONAL FAMILY MEMBER PROGRAM? ☐ YES ☐ NO

DISEASES AND ILLNESSES (CHECK Yes or No)

CHICKEN POX	☐ YES	☐ NO	RUBELLA	☐ YES	☐ NO	TEN-DAY MEASLES	☐ YES	☐ NO
MUMPS	☐ YES	☐ NO	POLIOMYELITIS	☐ YES	☐ NO	RHEUMATIC FEVER	☐ YES	☐ NO
SCARLET FEVER	☐ YES	☐ NO	OTHER (List)					

CHRONIC ILLNESSES AND CONDITIONS (Check Yes or No)

VISION PROBLEMS	☐ YES	☐ NO	AUDITORY PROBLEMS	☐ YES	☐ NO
ORTHOPEDIC PROBLEMS	☐ YES	☐ NO	ASTHMA	☐ YES	☐ NO
SEIZURE DISORDER	☐ YES	☐ NO	DIABETES	☐ YES	☐ NO
ALLERGIES					
OTHER (LIST)					

COMMENTS/INDICATE FREQUENCY

COLDS	EARACHES
STOMACH ACHES	HEADACHES
DIARRHEA	CONSTIPATION
BED WETTING	SLEEP DIFFICULTIES
POOR EATING HABITS	TANTRUMS
EXCESSIVE ACTIVITY	

DESCRIPTION OF SERIOUS CHRONIC ILLNESS/CONDITIONS (Medical Staff)		
ILLNESS/CONDITIONS	EARLY SYMPTOMS	RECOMMENDED CY&TP

COMMENTS:

ON-GOING MEDICATION (Medical Staff)			
TYPE	DOSAGE	FREQUENCY	CY&TP ADMINISTERED

MEDICAL STAFF COMMENTS

SPECIAL MEDICAL CONSIDERATIONS

DESCRIBE ANY SPECIAL PROGRAM NEEDS, CONSIDERATIONS, OR RESTRICTIONS, WHICH THE CHILD/YOUTH/TEEN REQUIRES IN ORDER TO PARTICIPATE IN CHILDREN/YOUTH PROGRAMS.

REFERRAL FOR EDIS/CHILD FIND SCREENING: ☐ YES ☐ NO

MEDICAL STATEMENT

The above named child/youth has been given a routine medical examination and has been found free of infectious or contagious diseases, and to be capable of participating fully in Children, Youth & Teen Programs with the exceptions listed above.

DATE	SIGNATURE OF MEDICAL FACILTY REPRESENTATIVE
DATE	SIGNATURE OF PARENT/GUARDIAN

(CY&TP 3/03)

UNITED STATES MARINE CORPS
Marine Corps Logistics Base
Marine Corps Family Team Building
814 Radford Blvd Ste 20311
Albany, Georgia 31704-0311

Dear Parent/Guardian:

Young children need healthy meals to learn. This letter is intended for parents or guardians of children enrolled at either a child care center or a family day care home. **Albany MCLB Child Development Center** 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 of the CACFP by completing the attached Income Eligibility Statement 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. Below are answers to common questions about the Program:

1. **Do I need to fill out an IES form for each adult in day care?** Yes. Complete and submit one IES form for each child in your household that is enrolled in a day care center or family day care home. 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: **Albany MCLB Child Development Center**. If your child (ren) is/are enrolled in a family day care home, **please do not return this form to your family day care provider.**

2. **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, should on this application.

3. **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 center or day care home.

4. **Who should I include as members of household?** You must include all people in your household, related or not (such as grandparents, other relatives, or friends who live with you). You must include yourself and all children who live with you.

5. **How do I report income information and changes in employment status?** The income you report must be the total gross income listed by source for 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 you household's income is equal to or less than the amounts indicated for your household's size on the attached Income Chart, the family day care home or center will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or proof of benefits as supported by a current Food Stamp, Temporary Assistance for Needy Families (TANF) or Food Distribution Program on Indian Reservations (FDPIR) case number, you will remain eligible for those benefits for a period not to exceed 12 months. You should, however, notify us if you or someone in your household becomes unemployed and the loss of income during the period of unemployment causes your household income to be within the eligibility standards (participants with family members who become unemployed are eligible for the free or reduced-price meals during the period of unemployment, provided that the loss of income causes the family income, during the period of unemployment, to be within the eligibility standards for those meals).

6. 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 but not if you only get it sometimes.

7. **What if I have foster children?** In certain cases foster children are eligible for free or reduced-price meals regardless of the income of such household with whom they reside.

Households wishing to apply for benefits for foster children should contact:

8. We are in the military. Do we include our housing allowance 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. All other allowances must be included in your gross income.

9. (Centers with Pricing Programs only) **Will the information I give be verified?** Maybe. We may ask you to send written proof to verify the information you submitted on the form. **What if I disagree with the decision about the information I complete on this form?** You should talk to your sponsoring organization. You may ask for a hearing by calling or writing to:

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

If you have any questions or need help, call 229-639-5269or 5481

Child Adult Care Food Program
Income Eligibility Statement

PART I: Child or Adult enrolled to receive day care-

Name: (Last, First and Middle Initial)	Food Stamp, TANF, or FDPIR case number, Assistant Unit (AU), or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. Note: Do not use EBT numbers.	Head Start Participant
		☐
		☐
		☐
		☐
		☐
		☐
		☐

PART II: FOSTER CHILD: **If this is a foster child, check here.** ☐ **In certain cases, foster children are eligible for free and reduced-priced meals regardless of household income. If foster children live with you, Skip to Part IV.**

PART III A: **A. Name** (List everyone in household, including children)	**B. Gross income and how often it is received** Example: $100/monthly, $100/twice a month, $100/every other week, $100/weekly				**C. Check if NO Income**
	1. Earnings from work before deductions	**2. Welfare, child support, alimony**	**1. 3. Social Security, pensions, retirement**	**4. All other income**	
1.	$______/______	$_______/______	$______/______	$_____/___	☐
2.	$______/______	$_______/______	$______/______	$_____/___	☐
3.	$______/______	$_______/______	$______/______	$_____/___	☐
4.	$______/______	$_______/______	$______/______	$_____/___	☐
5.	$______/______	$_______/______	$______/______	$_____/___	☐
6.	$______/______	$_______/______	$______/______	$_____/___	☐
7.	$______/______	$_______/______	$______/______	$_____/___	☐

PART III-B: ENROLLMENT INFORMATION: Children Only

My child is normally in attendance at the facility between the hours of _______ [am/pm] to _____ [am/pm] on the following days:

☐ Check here if only before/after school care is provided.

(Circle all that apply). Sunday Monday Tuesday Wednesday Thursday Friday Saturday

My child will normally receive the following meals while in care:

(Circle all that apply): Breakfast AM Snack Lunch PM Snack Supper Evening Snack

PART IV: Signature and Social Security Number (Adult must sign).

An adult household member must sign this form. If Part III is completed the adult signing the form must also list his or her Social Security number or mark the "I don't have a Social Security Number" box. (See Privacy Act Statement on next 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 purposefully give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Signature: X___________________________________ **Print Name** ___________________________________ **Date**_______________________

Address: ___________________________________ ___ **City** _______________________ **State: GA Zip**_________ **Phone** ___________________

Social Security Number ____________________________ ☐ I do not have a Social Security Number

PART V: Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:
☐ Hispanic or Latino ☐ Not Hispanic or Latino	☐ Asian ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander

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: ______ Date withdrawn _____________ Eligibility: Free _____ Reduced _____ Paid ______ Tier I _____ Tier II ______

Temporary: Free _____ Reduced _____ Time Period: ________________________ (expires after ______days)

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 Income
1	
2	
3	
4	
5	
6	
7	
8	
Each additional person	Add:

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 your child for free or reduced price meals. You must include the social security 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 Food Stamp, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: In accordance with Federal Law and I.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 to USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

INSTRUCTIONS

Households that receive Food Stamps, TANF, FDPIR, SSI or Medicaid: Complete the following:
Part I: For family day care home and child care center, list participant's name and a Food Stamp, TANF, or FDPIR case number. For adult day care, list participant's name and a Food Stamp, TANF, FDPIR, SSI or Medicaid case number.
Part II: Skip this part.
Part III-A: Skip this part.
Part III-B: Child care centers only. Provide the normal days and hours your child is in attendance in the center and indicate the meals he/she normally receives while in care.
Part IV: Sign the form. A Social Security Number is not necessary.
Part V: Answer this question if you choose to.

If you are applying on behalf of a Foster Child, complete a separate application for each foster child and complete the following:
Part I: For family day care home and child care center, list participant's name and a Food Stamp, TANF, or FDPIR case number. For adult day care, list participant's name and a Food Stamp, TANF, FDPIR, SSI or Medicaid case number.
Part II: Please contact us **[phone number].**
Part III-A: Skip this part.
Part III-B: Child care centers only. Provide the normal days and hours your child is in attendance in the center and indicate the meals he/she normally receives while in care.
Part IV: Sign the form. A Social Security Number is not necessary.
Part V: Answer this question if you choose to.

All other Households, including WIC households, complete the following:
Part I: For family day care home, child care center or adult day care, list participant's name .
Part II: Skip this part.
Part III-A: To report total household income from last month, complete the following:
Column A-Name: List the first and last name of each person living in your household as an economic unit. You must indicate yourself and all children living with you. In the case of an adult participant, the adult participant, and if residing with the adult participant, the spouse and dependent(s) of the adult participant. Attach another sheet if necessary.
Column B-Gross Income last month and how often it was received: Next to each person's name, list each type of income received last month, and how often it was received.
Box 1: List the gross income each person earned from work. This is not the same as take-home pay. Gross income is the amount earned before taxes and other deductions. The amount should be listed on your pay stub, or your boss can tell you. Next to the amount, write how often the person got it (weekly, every other week, twice a month, or monthly).
Box 2: List the amount each person got last month from welfare, child support, alimony.
Box 3: List Social Security, pensions, and retirement.
Box 4: List all other income sources including Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits IVA benefits), disability benefits, regular contributions from people who do not live in your household. Report net income from self-owned business, farm, or rental income. Next to the amount, write how often the person got it. If you are in the Military Housing Privatization Initiative do not include this housing allowance.
Column C-Check if no income: If the person does not have any income, check the box.
Part III-B: Child care centers only. Provide the normal days and hours your child is in attendance in the center and indicate the meals he/she normally receives while in care.
Part IV: An adult household member must sign the form, and list his/her social security number. Or, mark the box if he/she does not have one.
Part V: Answer this question if you choose to.

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

SHARING INFORMATION WITH MEDICAID/SCHIP

Dear Parent/Guardian:
If your children qualify for free or reduced price meals, they may also be able to get free or low cost health insurance through Medicaid or the State Children's Health Insurance Program (SCHIP). Children with health insurance are more likely to get regular health care and are less likely to become sick.

Because health insurance is so important to children's well-being, the law allows us to tell Medicaid and SCHIP that your children are eligible for free or reduced price meals, *unless you tell us not to.*

Medicaid and SCHIP only use the information to identify children who may be eligible for their programs. Program officials may contact you to offer to enroll your children in this health insurance program. Filling out the CACFP Meal Benefit Income Eligibility Forms does not automatically enroll your children in health insurance.

If you do not want us to share your information with Medicaid or SCHIP, fill out the form below and send it with your Income Eligibility Form to [address] by [date]. (Sending in this form will not change whether your children get free or reduced price meals.).

□ No! I DO NOT want information from my CACFP Meal Benefit Income Eligibility Form shared with Medicaid or the State Children's Health Insurance Program.

If you checked no, fill out the form below.
Child's Name: ____

Child's Name: ____

Child's Name: ____

Child's Name: ____

Signature of Parent/Guardian: ______________________________________

Today's Date: __________________________

Print Your Name: ____

Address:____

WIC

A Special Food and Nutrition Education Program

For Women, Infants and Children

WHO IS ELIGIBLE?

- A pregnant woman
- A breastfeeding woman
- A woman who has recently been pregnant
- An infant or a child less than 5 years old

TO BE ELIGIBLE, YOU MUST ALSO:

- Have a low or moderate income

  AND

- Have a special need that can be helped by WIC foods and nutrition counseling

YOU DO NOT HAVE TO BE ON PUBLIC ASSISTANCE

TO APPLY.

SERVICES PROVIDED:

- Nutritious foods
- Nutrition counseling
- Breast feeding support
- Health care referral

APPROVED WIC FOODS:

- Milk, cheese, eggs, cereals, peanut butter, fruit or vegetable juices, dry beans or peas, iron fortified formula

CALL YOUR LOCAL HEALTH DEPARTMENT FOR MORE INFORMATION.