DEPARTMENT OF DEFENSE CHILD DEVELOPMENT PROGRAM
REQUEST FOR CARE RECORD

(Read Privacy Act Statement and Instructions on back before completing form.)

OMB No. 0704-0515
OMB approval expires May 31, 2017

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM TO THE APPROPRIATE CHILD AND YOUTH PROGRAM REPRESENTATIVE.

1. DATE OF REQUEST *(YYYYMMDD)*	**2. EXPIRATION DATE** *(YYYYMMDD) (To be completed by Facility)*

3. FAMILY INFORMATION

a. SPONSOR'S NAME *(Last, First, Middle Initial)*	**b. SPONSE'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

(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)*

	a. FULL-DAY CARE		**d. FAMILY DAY CARE (FDC)**
	b. PART-DAY CARE		**e. PART-DAY ENRICHMENT**
	c. SCHOOL-AGE		**f. PRE-SCHOOL**

5. AGE GROUP *(X one)*

	a. INFANTS *(0 - 12 months)*
	b. TODDLERS *(13 - 35 months)*
	c. PRESCHOOL *(3 - 5 years)*
	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. FCC ON-INSTALLATION		**d. CIVILIAN CDC**		**g. IN-HOME CARE**
	b. FCC 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 IMPACTED? *(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. ACCOMMODATION UPDATES/REVERIFICATION *(For Office Use Only)*

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

USMC Children, Youth & Teen Programs Registration Form

OMB No. 0703-0068
OMB approval expires 31 OCT 2020

Privacy Act Statement

AUTHORITY: 10 U.S.C. 5013, Secretary of the Navy; 10 U.S.C. 5041, Headquarters, Marine Corps; DoD Instruction 6060.02, Child Development Programs; DoD Instruction 6060.4, Youth Programs; OPNAVINST 1700.9 series; Marine Corps Order 1710.30, Marine Corps Child and Youth Programs (CYP); and SORN NM01754-3

PURPOSE: Information provided is used by Children Youth and Teen Programs (CYTP) for purposes of patron registration in CYTP programs and activities and parent/guardian and emergency contacts.

ROUTINE USES: Any release of information contained in this system of records outside of DoD will be compatible with the purposes for which the information is collected and maintained. The DoD Blanket Routine uses may apply to this system of records.

DISCLOSURE: Information is voluntary; however, failure to provide information may adversely impact individuals from participation in CYTP activities.

SPONSOR INFORMATION

1. Name (First MI Last)	2. Address 1:	3. City/State/Zip Code:	4. Date

5. Home Phone (with area code):	6. Cell Phone (with area code):	10. Status: ☐ Active ☐ DoD Civilian Mil Grade _____ ☐ Retired ☐ Contractor
7. Address 2:		
8. Command/Unit/Employer:	9. Wk Ph: Ext.	11 Branch: ☐ Marine Corps ☐ Navy ☐ Air Force ☐ Army ☐ Other
12. Email:		13. Housing: ☐ On Base ☐ Off Base

SPOUSE / GUARDIAN INFORMATION

14. Name:(First MI Last)	15. Address 1(if different from above):	16. City/State/Zip Code:

17. Address 2:	18. Home Phone (with area code):	19. Cell Phone (with area code)

20. Command/Unit/Employer:	21. Wk Ph: Ext.	22.Status: ☐ Active ☐ DoD Civilian Mil Grade _____ ☐ Retired ☐ Contractor
23. Email:		24. Branch: ☐ Marine Corps ☐ Navy ☐ Air Force ☐ Army ☐ Other

LOCAL EMERGENCY CONTACT / RELEASE DESIGNEES

25. Name (first, last)	26. Address (include City/State/Zip Code)	27.Home Phone (with area code)	28.Cell Phone (with area code)	29. Relation to Child

FOR OFFICIAL USE ONLY
PRIVACY SENSITIVE - Any misuse or unauthorized disclosure can result in both civil and criminal penalties.

CHILDREN/YOUTH/TEEN INFORMATION

30. Child/Youth/Teen 1 First & Last Name | Nick Name

Gender ☐ Male ☐ Female Birthdate _____ School Grade _____ (K-12) or N/A

Program Enrollment:

☐ Full Day Care ☐ Part Day Preschool ☐ Family Child Care ☐ Hourly Care
☐ School Age Care (BF/AF) ☐ School Age Care (BF) ☐ School Age Care (AF) ☐ School Age Day Camp
☐ Youth Program ☐ Teen Program ☐ Other _____ ☐ Off Base Family Child Care

31. Child/Youth/Teen 2 First & Last Name | Nick Name

Gender ☐ Male ☐ Female Birthdate _____ School Grade _____ (K-12) or N/A

Program Enrollment:

☐ Full Day Care ☐ Part Day Preschool ☐ Family Child Care ☐ Hourly Care
☐ School Age Care (BF/AF) ☐ School Age Care (BF) ☐ School Age Care (AF) ☐ School Age Day Camp
☐ Youth Program ☐ Teen Program ☐ Other: _____ ☐ Off Base Family Child Care

32. Child/Youth/Teen 3 First & Last Name: | Nick Name:

Gender ☐ Male ☐ Female Birthdate _____ School Grade _____ (K-12) or N/A

Program Enrollment:

☐ Full Day Care ☐ Part Day Preschool ☐ Family Child Care ☐ Hourly Care
☐ School Age Care (BF/AF) ☐ School Age Care (BF) ☐ School Age Care (AF) ☐ School Age Day Camp
☐ Youth Program ☐ Teen Program ☐ Other: _____ ☐ Off Base Family Child Care

33. Please answer the following questions by checking the correct box.	Yes	No
I allow use of video and photographs of my child within the CYTP program.		
I approve my child/youth to attend field trips.		
I have received a copy or was given the website on where to get a "Parent Handbook".		
I give my permission for child to use supervised computers and internet.		
I have received two CYMS cards per child.		

34. Parent/Guardian Signature | 35. Date

For office use only

Registration Fee:	Child Care Fee:	Receipt #:	Amount Paid:	Paid on:	Received by:

Pass Issued: ☐ CY-Child ☐ CY-SAC ☐ CY-YT ☐ CY-YZZ-Privilege Pass

FOR OFFICIAL USE ONLY
PRIVACY SENSITIVE - Any misuse or unauthorized disclosure can result in both civil and criminal penalties.

MCAS Cherry Point
Children and Youth Programs
Child Development Center
Release from Liability Taking of Temperatures / Infant Sleep Policy

Release of Liability/Taking Temperatures

I, the parent/guardian of _____/_____ understand that neither Marine Corps no Navy Policies require the taking of children's temperatures to determine illness while enrolled for care at a military child care facility. I further understand that the Children and Youth Program (CYP) personnel take temperatures only as a courtesy to the children's parents or guardians and that a staff member will always ensure a child's parent or guardian is contacted whenever, in that staff member's opinion, a child "looks or acts sick". I also understand that it will then be my responsibility to seek further evaluation and diagnosis by an authorized medical provider.

I further understand that CYP personnel ARE NOT TRAINED MEDICAL PROVIDERS and therefore, may misreport a child's temperature due to misreading or misuse of the thermometer, or by using a defective thermometer. I also understand that injury or death could result to my child should I fail to seek medical evaluation based upon erroneous temperature reading reported by a staff member.

Consequently, based upon my understanding of the risks involved in relying on bodily temperature readings furnished by CYP, I hereby agree to release and hold harmless the United States Government, including the U.S. Marine Corps, Marine Corps Community Services (MCCS) , CYP, their offices, employees, agents, personnel, successors and assigns from any and all claims, damages, liabilities, losses, injuries, deaths, costs and expenses including attorney's fees and costs of suits arising out of or claimed on account of "courtesy temperature checks" furnished by staff members to assist in determining whether my child should receive child care or stay home due to illness.

Parent/Guardian Signature_____ **Date**_____

FOR PARENTS OF INFANTS ONLY

INFANTS SLEEP POSITION POLICY/PARENT AGREEMENT

In accordance with the American Medical Academy for Pediatrics, the National Institute of Child Health and Human Development and the National Association of the Education of Young Children, the children and Youth Programs at Cherry Point support and adhere to the best practices to ensure infants are well cared for and safe. Research supports that the easiest practice to lower a baby's risk of Sudden Infant Death Syndrome is to put the infant on his/her back to sleep. We support the Back to Sleep Program and will place all young infants on their backs to sleep.

I have read, understand and agree to abide by the CYP Infant Sleep Position Policy. I understand failure to comply with this policy will result in disenrollment.

Parent/Guardian Signature_____ **Date**_____

MCAS Cherry Point
Children and Youth Program
Child Development Center and Cherry Tree House
Discipline and Touch Policy

Child Guidance and Discipline Policy

Our Goal is to promote self-control and appropriate social behavior in children and youth. We use positive methods to encourage development of these behaviors. Positive guidance helps children learn what is acceptable and what is not and helps children learn to make their own decisions.

Childcare providers set behavior limits based on positive guidance and redirection as they focus on teaching rather than punishing. Aggressive behaviors are most often present when children lack the skills to cope with frustrating situations and are to be handled by validating the child's feelings and / or redirecting the child to another activity. Time out should be used appropriately. Time out should only be used as a last resort and only if the child is hurting him/herself, hurting others or destroying property.

Verbal abuse (including yelling or raised voices, threats and derogatory remarks) and any type of physical punishment such as squeezing to cause pain, jerking or pulling a child, slapping, hitting, restricting a child's movement or placing the child in an isolated or confined space are all forbidden and are grounds for immediate dismissal. Withholding or forcing meals, snacks or naps are also forbidden.

Our guidance strategies include:

- Use of clear directions
- Communication of age appropriate positive expectations/consequences
- Modeling appropriate verbal responses to conflicts
- Positive reinforcement
- Listening to the child
- Avoiding labeling of children
- Providing challenging activities or redirecting to alternate activities
- Ignoring behavior when appropriate to do so.

Touch Policy

Physical contact is important for a child's development. A child/youth's self-esteem grows when they are cared for in a loving manner. Holding hands, a pat on the buck, a reassuring hug (lasting 3 seconds or less), and for younger children, a lap to sit on and a reassuring back rub at nap time are all examples of nurturing gestures. These expressions of affection are natural for adults who work with children.

INAPPROPRIATE TOUCHING IS GROUNDS FOR IMMEDIATE DISMISSAL FOR ANY STAFF MEMBER

Some obvious examples of inappropriate touch are:

- Shoving - Biting - Squeezing -Corporal Punishment
- Head and/or arm twisting - fondling - Pinching

Parent/Guardian Signature _____ **Date** _____

Family Advocacy Program (FAP) 466-3264
24/7 National Domestic Violence Hotline 1-800-799-7233(SAFE)

USMC Children, Youth & Teen Programs (CYTP) Health Assessment

OMB No. 0703-0068
OMB approval expires 31 OCT 2020

Privacy Act Statement

AUTHORITY: 10 U.S.C. 5013, Secretary of the Navy; 10 U.S.C. 5041, Headquarters, Marine Corps; DoD Instruction 6060.02, Child Development Programs; DoD Instruction 6060.4, Youth Programs; OPNAVINST 1700.9 series, Marine Corps Order 1710.30, Marine Corps Child and Youth Programs (CYP); and SORN NM01754-3.

PURPOSE: The information collected on this form is used by Children, Youth and Teen Programs (CYTP) and Inclusion Action Team personnel to determine the general health status of patrons participating in CYTP activities and if necessary the appropriate accommodations for the patron for full enjoyment of CYTP services.

ROUTINE USES: Any release of information contained in this system of records outside of DoD will be compatible with the purposes for which the information is collected and maintained. The DoD Blanket Routine uses may apply to this system of records.

DISCLOSURE: Information is voluntary; however, failure to provide information may adversely impact individuals from participation in CYTP activities.

PLEASE DO NOT RETURN YOUR RESPONSE TO THE ABOVE ADDRESS.

Responses should be sent to your Regional Director.

SPONSOR INFORMATION (please print)

1. Name of Sponsor	2. Home Phone	3. Sponsor Unit
	4. Cell Phone	5. Duty/Work Phone

CHILD/YOUTH INFORMATION (please print)

6. Name of Child/Youth	7. Birth Date	8. ☐ Male ☐ Female	9. Enrolled in Public School ☐ Yes ☐ No

CHILD'S/YOUTH'S MEDICAL HISTORY (Check all that apply)

10. Any hospitalization or operations		23. Heat stroke or exhaustion		36. If any apply, please explain
11. Allergies to medicine, insect bites, latex or food (please explain reactions)		24. Benign Skin Colorations (e.g. birthmarks		
12. Development delays/Learning problems		25. Joint injuries		
13. Eye or vision Problems (Glasses/Contacts)		26. Restricted physical activity		
14. Ear or hearing problems		27. Diabetes		
15. Seizures or Convulsions		28. Cancer		
16. Dizziness or fainting with exercise		29. Dental problems		
17. Headaches		30. Mental Health Issues		
18. Head injury or loss of consciousness		31. Sleep problems		
19. Neck or back injury		32. Behavioral problems		
20. Asthma or difficulty breathing		33. ADD/ADHD		
21. Heart or blood pressure problems		34. Broken bones or sprains		
22. Chest pain with exercise		35. Other problems		

37. Is the child/youth enrolled in Exceptional Family Member Program? ☐ Yes ☐ No

38. In what branch of Service

39. Does the child/youth have ongoing medical concerns or special needs/considerations that have required the care of a Healthcare Provider within the last year? (If Yes, explain circumstances and current status) ☐ Yes ☐ No

If there are special considerations, a Health Screening Tool for Inclusion Action Team (page 3) must be completed by the Healthcare Provider.

USMC Children, Youth & Teen Programs (CYTP) Health Assessment

PHYSICAL EXAMINATION (To be completed by Healthcare Provider)(May attach last physical if within last 12 months)

40 Height	41 Weight	42 BP	43 HR

	Normal	Abnormal	N/A		Normal	Abnormal	N/A
44 Eyes				51 Chest/ Abdomen			
45 ENT				52 Genitalia			
46 Hearing				53 Skin			
47 Mouth/Teeth				54 Lymphatic			
48 Neck				55 Spine			
49 Cardiovascular				56 Extremities			
50 Respiratory				57 Neurological			

58 Based on this examination, the following abnormalities were found

59 Immunizations are current and up to date ☐ Yes ☐ No (if no, please explain) **A copy of the child/youth immunization must be given to CYTP**

60 Child/Youth is able to participate in normal CYTP programs? ☐ Yes ☐ No (if no, please explain)

61. Date	**62. Parent or Guardian Signature**	**67. Healthcare Provider Stamp or Printed Name & Address**
63. Date	**64. Healthcare Provider Signature**	
65. Date	**66. Healthcare Provider Signature**	

USMC Children, Youth & Teen Programs (CYTP)

Health Screening Tool for Inclusion Action Team (IAT)

REQUIRED ONLY IF THE CHILD/YOUTH HAS SPECIAL NEEDS/CONSIDERATIONS. TO BE COMPLETED BY PARENT AND HEALTHCARE PROVIDER OR APPROPRIATE SPECIALIST

Identification of Child/Youth Special Need(s) (use provided space to elaborate on the special need)

68. What special need(s) does the child/youth have?

Asthma/Reactive Airway Disease ☐ Allergies (other than seasonal/allergic rhinitis) ☐ Behavioral ☐ Neurological ☐
Developmental (e.g. Autism/PDD/Delays) ☐ Other ☐ (explain)

69. Brief summary of the child's/youth's needs

Medication

70. Child is on medications related to special needs? ☐ No ☐ Yes (list medications below and indicate which require administration during child care hours)

71. For medically diagnosed allergies, is Epinephrine required? ☐ No ☐ Yes

72. For other diagnoses, are any emergency medications required (e.g. Glucagon, Diastat, Albuterol)? ☐ No ☐ Yes

CURRENT MEDICATIONS INCLUDING EMERGENCY (If more space is needed, please attach additional documents)

73. Name	74. Dosage	75. Frequency	76. During Child Care
			☐
			☐
			☐

77. Assistance with activities of daily living? ☐ No ☐ Yes (explain)

78. Medical Dietary modifications? ☐ No ☐ Yes (explain)

79. Environmental adaptations (e.g. room temperature, wheelchair access)? ☐ No ☐ Yes (explain)

80. Other conditions/adaptations/modifications/recommendations/concerns or comments to ensure the child's/youth's needs are met? ☐ No ☐ Yes (specify and explain)

81. Healthcare Provider or Specialist Signature	**82. Date**	**83. Provider/Specialist Stamp or Printed Name & Address**
84. Phone	85. E-mail	

86. Carry and Self-Administer Authorization (to be initialed by the healthcare provider)

	I have instructed this youth in the proper way to use his/her medication. It is my professional opinion that he/she SHOULD be allowed to carry and self administer his/her medication. This youth has been instructed not to share medications.
	It is my professional opinion that this child/youth SHOULD NOT carry or self administer his/her medication.

For youth who self-administer and carry their own medication(s), the medication MUST accompany the youth at all times. The options of storing "back up" rescue medications at the program is available. The youth must not share medications. Should the youth violate these restrictions the privilege of self medicating will be revoked and the youth parents notified. Youth are required to notify staff when carrying medication upon check in at CYTP activity.
*Rescue medications MUST accompany children/youth during any off-site activities.

Early Intervention and Special Education

87. Child has an Individualized Family Service Plan (IFSP), Individualized Education Plan (IEP), 504 plan or Behavioral Plan? ☐ No ☐ Yes

88. If yes, does he/she have an aide, skills trainer, or additional assistance? ☐ No ☐ Yes

89. For Special Ed/Early Intervention, is the child currently seeing a therapist? ☐ No ☐ Yes

I understand that all reasonable efforts will be made to accommodate all properly documented special needs based on IAT determinations. Parent/guardian(s) will be notified if care accommodations cannot be honored and invited to attend subsequent meetings. I acknowledge that CYTP is not responsible for providing the child/youth with services that would be considered skilled nursing or behavioral, occupational, or physical therapy.
I understand that this form must be updated annually, or earlier, if there is a change in condition or need.

90. Parent/Guardian Signature	91. Date

Office Use Only-Reviewed by CYTP Nurse or Other Designated Personnel

92. Signature	93. Date	94. IAT Meeting date if required

FOR OFFICIAL USE ONLY
PRIVACY SENSITIVE - Any misuse or unauthorized disclosure can result in both civil and criminal penalties.

PARENT GUARDIAN/HOUSEHOLD LETTER FOR NON-PRICING INSTITUTIONS
CHILD AND ADULT CARE FOOD PROGRAM

Dear Parent or Guardian,

Please help us comply with the federal requirement mandating the annual submission of program Income Eligibility Application. This application will be used only for eligibility determination, placed in our files and treated as confidential information. In order for participants and the day care center to be considered eligible for program benefits, an adult household member must complete the program Income Eligibility Application (IEA) for each participant enrolled in the center as soon as possible, sign, date and return it to the day care center. Completion of the application is not mandatory unless you wish to be considered for eligibility as a free or reduced price participant.

If you currently receive SNAP, Temporary Aid to Needy Families (TANF) or Food Distribution Program on Indian Reservations (FDPIR), you are not required to list household income. You may give your SNAP, TANF or FDPIR case number, sign, date and return the application. If a child is a member of a SNAP or FDPIR household or is a TANF recipient, the child is automatically eligible to receive free program meal benefits, subject to completion of the application.

You should also note that if you have a foster child the day care center is eligible for program benefits for the foster child regardless of the income of your household. Households with foster and non-foster children may choose to include the foster child as a household member, as well as any personal income earned by the foster child, on the same household application that includes their non-foster children. Please contact the institution for further instructions.

You should list the name of everyone who lives in your household, including all children, parents, grandparents and other relatives. The Department of Agriculture defines a household as a group of related or unrelated individuals (not residents of an institution or boarding house) who are living as one economic unit (i.e. sharing living expenses).

The income which you report **must** be the total gross income, before deductions, received by all members of your household last month (i.e. wages, public assistance, TANF or retirement, etc.). Military benefits received in cash, such as housing allowance for military households living off base and food or clothing allowance **must** be considered as income. If you have a household member whose last month's income was higher or lower than usual, list that person's expected average monthly income.

REDUCED GUIDELINES EFFECTIVE JULY 1, 2019 - JUNE 30, 2020*

HOUSEHOLD SIZE	YEARLY	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY
1	$23,107	$1,926	$963	$889	$445
2	$31,284	$2,607	$1,304	$1,204	$602
3	$39,461	$3,289	$1,645	$1,518	$759
4	$47,638	$3,970	$1,985	$1,833	$917
5	$55,815	$4,652	$2,326	$2,147	$1,074
6	$63,992	$5,333	$2,667	$2,462	$1,231
7	$72,169	$6,015	$3,008	$2,776	$1,388
8	$80,346	$6,696	$3,348	$3,091	$1,546
For each additional family member add:	$8,177	$682	$341	$315	$158

*Households with income less than or equal to these levels are eligible for free or reduced-price meals.

You may submit a program Income Eligibility Application any time during the fiscal year. Participants having family members who become unemployed are eligible for free or reduced-price meals during the period of unemployment, provided that the loss of income causes the family's income during the period of unemployment to be within the eligibility standards for those meals.

In accordance with Federal 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 U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 by fax (202) 690-7442 or email program.intake@usda.gov. This institution is an equal opportunity provider.

Child and Adult Care Food Program (CACFP)
Child Participant Enrollment Form

Institution Name: MCAS CHERRY POINT CYP Agreement Number: 7177

Center Name: 4298/4629/4859/CTH

Dear Parent/Guardian,
This center/program receives funding from the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). CACFP needs proof of enrollment for all children. Please complete the table below for each child in your family that is enrolled at this center/program. Be sure to sign and date in the space below. Thank you.

The information below should be completed by the parent or guardian.

Child's First Name	Child's Last Name	Date of Birth	Normal/Typical Hours of Care	Normal/Typical Days of Care (Circle all that apply)	Meals Normally Eaten (Circle all that apply)
			____ to ____	M T W Th F Sat Sun	B AM L PM S LPM
			____ to ____	M T W Th F Sat Sun	B AM L PM S LPM
			____ to ____	M T W Th F Sat Sun	B AM L PM S LPM
			____ to ____	M T W Th F Sat Sun	B AM L PM S LPM
			____ to ____	M T W Th F Sat Sun	B AM L PM S LPM

Normal/Typical Hours of Care: Please write in each child's usual arrival and departure time. Indicate a.m. or p.m.
Normal Days of Care: Please circle the days of the week each child is usually in attendance at the facility.
(M-Monday; T-Tuesday; W-Wednesday; Th- Thursday; F-Friday; Sat-Saturday; Sun-Sunday)
Meals Normally Eaten – Please circle the meals each child usually eats at the facility.
(B-Breakfast; AM-AM Snack; L-Lunch; PM-PM Snack; S-Supper; LPM-Late PM/Evening Snack)

Parent/Guardian Signature: _____ **Date:** _____

Print Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone Number: ( ) _____ Work Telephone Number: ( ) _____

For Facility/Provider Use Only:
Signature of Facility Representative/Provider: _____ Date: _____

Date each child withdrew: _____

For State Use Only: Complete ___ Incomplete ___ Reason _____ Verified by _____ Date _____

This institution is an equal opportunity provider

NC CACFP Enrollment Child (06/19)

North Carolina Department of Health and Human Services
Women's and Children's Health
CHILD AND ADULT CARE FOOD PROGRAM
CHILD ELIGIBILITY APPLICATION

1. PRINT PARTICIPANT'S NAME & DATE OF BIRTH:

INSTITUTION NAME: MCAS CHERRY POINT CYP

AGREEMENT#: 7177

FACILITY NAME: 4298/4629/4859/CTH

First Name Last Name Date of Birth

First Name Last Name Date of Birth

2. SNAP, TANF or FDPIR: If a child is a member of a SNAP or FDPIR household or TANF recipient, the child is automatically eligible to receive free Program meal benefits, subject to the completion of the application. If the household currently receives SNAP, TANF or FDPIR benefits give the case number.

Case number is: **SNAP #** _____ **TANF#:** _____ **FDPIR #**_____
If you have provided the case number, **DO NOT complete #3 and #4. Complete #5 and #6.**

3. A foster child is automatically eligible to receive free Program meal benefits, and a Head Start participant is automatically eligible to receive free Program meal benefits, subject to submission by Head Start officials of a Head Start statement of income eligibility or income eligibility documentation.

Is this a Foster Child? Yes No

Households with foster and non-foster children may choose to include the foster child as a household member, as well as any personal income earned by the foster child, on the same household application that includes their non-foster children.

4. HOUSEHOLD MEMBERS MONTHLY INCOME: List all others living in your household, **DO NOT** include participant listed above. List all gross income **(before deductions)** received last month. If you did not give a SNAP, TANF or FDPIR case number or if this is not a foster child, you must complete the income information.

Names of all Other Household Members	Monthly Wages Salaries	Monthly Social Security Earnings	Monthly Public Assistance/ Child Support Earnings	Monthly Retirement Pensions Earnings	Monthly Other Earnings
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$

5. ETHNIC IDENTITY: (Check one). Hispanic or Latino Not Hispanic or Latino

RACE (Check one or more): White Black or African American American Indian or Alaskan Native Asian
Native Hawaiian or Other Pacific Islander

6. SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER: **I certify that all of the above information is true and correct; that the application is being made in connection with the receipt of federal funds, that Program officials may verify the information on the application; and that deliberate misrepresentation of any of the information on the application may subject me to prosecution under applicable State and Federal criminal statutes.**

Signature of Adult Household Member (Required) Date

Check if no SSN

Last Four Digits of Social Security Number
(Required for households qualifying by income)

Printed Name

Home Telephone # Work Telephone #

Address City Zip Code

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

For Institution to be classified and completed by institution/sponsor

TOTAL HOUSEHOLD SIZE: _____ TOTAL HOUSEHOLD MONTHLY INCOME: $ _____

Approved Free Reduced Denied

Reason for denial Income too high Incomplete application Other _____

Withdrew on (Date) _____

For state use only:
Verified by: _____ Date: _____
Verified classification
Free Reduced Denied
Reason for classification change: _____

Signature of Eligibility Official (Individual at the Institution Level) – REQUIRED **Date**

This institution is an equal opportunity provider

NC CACFP ELIGIBILITY APPLICATION INSTRUCTIONS

Please complete the Child and Adult Care Food Program Eligibility Applications using the instructions below. Sign the certification statement and return it to your child care center.

PART 1-PARTICIPANT'S INFORMATION: Complete this part.
Print the name(s) of the child enrolled in the center.

PART 2-HOUSEHOLD GETTING SNAP, TANF, OR FDPIR BENEFITS: Complete this PART and PART 6.
(1) List your current SNAP, TANF, or FDPIR case identification number.
(2) An adult household member must sign the certification statement in PART 6.

PART 3-FOSTER or HOMELESS CHILD (Including children evacuated from Japan and Bahrain)
(1) Indicate if child is a Foster Child or is homeless. Households with foster and non-foster children may choose to include the foster child as a household member, as well as any personal income earned by the foster child, on the same household application that includes their non-foster children. Additionally, when a host family applies for free and reduced price meals for their own children, the host family may include the homeless family as household members if the host family provides financial support to the homeless family. In such cases, the host family must also include any income received by the homeless family.
(2) An Adult household Member must sign the certification statement in PART 6.

PART 4- HOUSEHOLD INCOME: Complete this PART and PART 6
(1) List the names of household members.
(2) Write the amount of income (the amount before taxes or anything else is taken out), the frequency of income (i.e. weekly, every two weeks, twice a month, or monthly) received **last month** for each household member and where it came from, such as earnings, public assistance, pensions and other income (refer to examples below for types of income to report). If any amount last month was less than usual, write the person's usual income.
(3) An adult household member must sign this income eligibility statement and give the last four digits of his/her social security number in PART 6.

PART 5-RACIAL/ETHNIC IDENTITY: Complete the Ethnic/Racial identity question.

PART 6-SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER: All households complete this PART.
(1) All eligibility applications must have this signature of an adult household member;
(2) The adult household member who signs the certification statement must include the last four digits of his/her social security number. If he/she does not have a social security number, write "none". If you listed a SNAP, TANF, or FDIR number a social security number is not needed.

INCOME TO REPORT

Earnings from Employment	Pensions/Retirement/Social Security	Other Income
• Wage/salaries/tips • Strike benefits • Unemployment compensation • Net income from self-owned business or farm • Worker's compensation Public Assistance/Child Support/Alimony • Public assistance payments • TANF payments • Alimony/Child support payments	• Pensions • Supplemental security income • Retirement income • Veteran's payments • Social Security Military Households • All cash income, including military housing/uniform allowances. Does not include "in-kind" benefits NOT paid in cash (base housing, clothing, food, medical care, etc.)	• Disability benefits • Cash withdrawn from savings • Interest/dividends • Income from estates/trusts/ investments • Regular contributions from persons not living in the household • Net royalties/annuities/ net rental income • Any other income