# 2021-2022 After School Program

## Child's Information

Program Start Date: _____

First AND Last Name: _____ School: _____

Address: _____ City/State/Zip: _____

Gender: Male or Female Age: _____ Date of Birth: _____ Grade: _____

Child lives with: mother father both other: _____

## Parent/Legal Guardian

First AND Last Name: _____

Address: _____

Relationship to child: _____ Cell #: _____

Place of work: _____ Work #: _____

Email: _____

**Parents/Legal guardian listed above will be automatically sent a registration link for the Remind texting system to receive alerts pertaining to information regarding Day Camp information, Kids Night Out, & your child's After School account**

## Parent/Legal Guardian

First AND Last Name: _____

Address: _____

Relationship to child: _____ Cell #: _____

Place of work: _____ Work #: _____

## Emergency Contact

Additional person in case of emergency. **DO NOT** list parent/legal guardians.

First AND Last Name: _____

Address: _____

Relationship to child: _____ Cell #: _____

Place of work: _____ Work #: _____

## Authorized Pick-Up

Additional people authorized to pick up my child other than those listed above.

First AND Last Name: _____

Relationship to child: _____ Cell #: _____

First AND Last Name: _____

Relationship to child: _____ Cell #: _____

First AND Last Name: _____

Relationship to child: _____ Cell #: _____

Child's first AND last name: _____

## Health Information

**2021-2022 After School Program**

Your child's immunization record must be on file with your child's school, please indicate the school & information below:

| School Name: | School Address: | School Phone: |
|---|---|---|
| | | |

In the event of an emergency and the parent/legal guardian is not available, your designated hospital will be contacted for emergency/medical transportation and/or treatment. Please check the hopsital in which you would like us to contact.

| **Must Check One:** | ☐ Shannon South<br>3501 Knickerbocker Road<br>San Angelo, TX 76904<br>325-949-9511 | ☐ Shannon Medical Hospital<br>120 E. Harris Ave<br>San Angelo, TX 76903<br>325-653-6741 | ☐ Concho Valley ER<br>5709 Sherwood Way<br>San Angelo, TX 76901<br>325-703-6900 |
|---|---|---|---|

**Food Allergies** **all children with food allergies must have an Allergy Form on file at the YMCA before enrollment is accepted**

List Foods: _____

**Non-Food Related Allergies**

List Allergies: _____

## Behavioral Information

Behavioral Issues/Special Needs:

| | | |
|---|---|---|
| HEAD START: Can your child participate in a 1:15 ratio? (1 staff with 15 kids) | YES | NO |
| SCHOOL AGE: Can your child participate in a 1:22 ratio? (1 staff with 22 kids) | YES | NO |
| Does your child run from adults? | YES | NO |
| Is your child prone to severe breakdowns or fits? | YES | NO |
| Will the child require medication to be given at the after school location? | YES | NO |
| Does your child have an epi-pen for allergies? (if yes, please provide) | YES | NO |
| Does your child have a behavioral diagnosis? | YES | NO |

Please list and explain: _____

What strategies work best if your child gets upset? _____

What are your child's limitations? _____

**Additional Informaton:**

In order to best meet your child's needs, we require that you list any other special needs that your child may have, such as physical limitations, emotional or behavioral issues, allergies, existing illness, previous serious illness, injuries/hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information the staff should be aware of. _____

## Policy Acknowledgements

**By enrolling my child in the program, I understand and agree to follow all policies outlined in the parent handbook (provided to you at registration). By signing, you give your child permission for the following:**
**To be photographed/videotaped for YMCA or United Way purposes (no names will be released).**
**To participate in water activtites, including swimming (life jackets will be provided to those who need them).**
**To be treated medically by a physician and transported to a hospital (in the event of an emergency).**
**To be transported by YMCA or TLCA buses for field trips (permission slips will be administered).**

Parent/Guardian Signature: _____ Date: _____

# FP Assistance

Feeding the Future

## Enrollment Form

Center Name: _____ Site Code: _____

Child's Name: _____ Date of Birth: ____/____/____

Admission date: ____/____/____ Withdrawal Date: ___/____/____ Classroom: _____

1. Circle the days that your child will <u>normally</u> attend the center:

   **Mon Tue Wed Thu Fri Sat Sun**

2. Circle the meals <u>normally</u> served to your child in the center:

   **Breakfast AM Snack Lunch PM Snack Supper Evening Snack**

3. What hours will your child <u>normally</u> be in the center:

   ____:_____ **to** ____:_____

4. Participant's ethnic and racial identities

   **Ethnicity (choose one ethnic identity):**

   ☐ Hispanic or Latino ☐ Not Hispanic or Latino

   **Race: (choose one or more racial identities):**

   ☐ Asian ☐ American Indian or Alaska Native

   ☐ White ☐ Native Hawaiian or Other Pacific Islander

   ☐ Black or African American

| | Parent Signature | Date of Signature | Day Time Phone Number |
|---|---|---|---|
| 1) | _____ | _____ | (____) ____-____ |
| 2) | _____ | _____ | (____) ____-____ |
| 3) | _____ | _____ | (____) ____-____ |
| 4) | _____ | _____ | (____) ____-____ |

# INSTRUCTIONS FOR
# CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM
# (CHILD CARE)

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

**Part 1:** List all enrolled children and household members.
**Part 2:** List the eligibility number for any household members (including adults) receiving SNAP or TANF or FDPIR benefits. The SNAP or TANF number must be the 8 or 9 digit EDG# assigned by HHSC.
**Part 3:** Skip this part.
**Part 4:** Skip this part.
**Part 5:** Sign the form. The last four digits of a Social Security Number are **not** necessary.
**Part 6:** Answer this question if you choose.
**Part 7:** Answer this question if you choose.

**If you are applying on behalf of a FOSTER CHILD, follow these instructions:**

If **all** children you are applying for are foster children, or if you are only applying for benefits for the foster child:

**Part 1:** List all foster children. Check the box indicating that the child is a foster child.
**Part 2:** Skip this part.
**Part 3:** Skip this part.
**Part 4:** Skip this part.
**Part 5:** Sign the form. A Social Security Number is **not** necessary.
**Part 6:** Answer this question if you choose.
**Part 7:** Answer this question if you choose.

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

**Part 1:** List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster child.
**Part 2:** If the household does not have an eligibility number, skip this part.
**Part 3:** **Applies only to parents/guardians of children in Tier II Day Care Homes**. Sponsors must provide the *List of Eligible Federal/State Funded Programs* (H1660), with this form to households with children enrolled in Tier II Day Care Homes. Parents/Guardians can enter the program name and number as applicable.
**Part 4:** Follow these instructions to report total household income from this month or last month.

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

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

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

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

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

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

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

**Part 6:** Answer this question if you choose.

**Part 7:** Answer this question if you choose.

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

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

**Part 2:** Skip this part.

**Part 3:** Skip this part.

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

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

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

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

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

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

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

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

**Part 6:** Answer this question if you choose.

**Part 7:** Answer this question if you choose.

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

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

# CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

**Part 1. All Household Members**

**Name of Enrolled Child(ren):** _____

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

**Part 2. Benefits:** If any member of your household receives SNAP, TANF, or FDPIR, provide the name and eligibility number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:_____ ELIGIBILITY NUMBER: _____

**Part 3. (Applies only to parents/guardians with children enrolled in a day care home)** If any member of your household receives benefits listed on the enclosed *List of Eligible Federal/State Funded Programs (H1660)*, provide the name of the program and eligibility number: NAME: _____ ELIGIBILITY NUMBER: _____

Check here if no eligibility number ☐

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

| **A. Name** (List **only** household members with income) | **B. Gross income and how often it was received** **Note:** Self-employed report income after expenses in box 1 | | | |
|---|---|---|---|---|
| | 1. Earnings from work before deductions | 2. Welfare, child support, alimony | 3. Pensions, retirement, Social Security, SSI, VA benefits | 4. All Other Income |
| *(Example)* *Jane Smith* | $200/weekly | $150/twice a month | $100/monthly | $200/bi-monthly |
| | $____/____ | $____/____ | $____/____ | $____/____ |
| | $____/____ | $____/____ | $____/____ | $____/____ |
| | $____/____ | $____/____ | $____/____ | $____/____ |
| | $____/____ | $____/____ | $____/____ | $____/____ |
| | $____/____ | $____/____ | $____/____ | $____/____ |

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

An adult household member must sign this form. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the 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 purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.*

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City:_____ State: _____ Zip Code: _____

Last four digits of Social Security Number: _ _ _ - _ _ - _ _ _ _ ❑ I do not have a Social Security Number

# CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

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

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

**Part 7. Sharing Information With Other Programs: OPTIONAL**

The above information may be disclosed for the purpose of enrolling children in the Children's Health Insurance Program (CHIP). Parents/guardians are not required to consent to such disclosure and electing not to allow disclosure will not adversely affect a child's eligibility.

☐ **I do elect to allow my household information to be disclosed.**

☐ **I do not elect to allow my household information to be disclosed.**

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

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

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

Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free___ Reduced___ Denied___ Tier I_____ Tier II____

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date:_____

**Privacy Act Statement:**

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

**Non-discrimination Statement:**

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:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.