CDC Enrollment Package FY2017

ELIGIBILITY & ENROLLMENT

This enrollment packet requests information about the Sponsor. Sponsors must be the parent or legal guardian of the child they are enrolling. Children must reside on a full time basis within the home of the sponsor.

*Eligibility & Enrollment Statement per

Marine Corps Order 1710.30F

In Section 4 a. - Eligibility and Enrollment

Eligible users shall include military personnel; DoD civilian personnel paid from appropriated funds (APF's) and non appropriated funds (NAF's), active duty Coast Guard, reservists on active duty or during inactive duty for training, and DoD contract personnel who are performing mission related duty on the installation. Retirees may be eligible when a waiting list does not exist and space is available.

RETURN COMPLETED FORMS TO:

CYP Central Enrollment Office
Resource & Referral
229-639-7930 DSN 567-7930
Fax: 229-639-5096
Email:
mclbarr@usmc-mccs.org
Hardcopy:
814 Radford Blvd, Building 7600
Suite 20311
Albany, GA 31704-0311

Two business days are required to properly process completed enrollment packages, renewals and returns from Drop In care.

DOCUMENTS REQUIRED FOR ENROLLMENT:

1. Completed Enrollment Package
2. Current Pay Stubs/LES for all members of the household regardless of martial status
3. Current Immunizations on GA form *(Including Influenza Vaccine)*
4. Health Assessment
5. Family Care Plan (Required for Single or Dual Active Duty Members Only)

CLASSROOM RATIOS:

Infants:
4 Children : 1 Teacher

Pre-Toddlers:
5 Children : 1 Teacher

Toddlers:
7 Children : 1 Teacher

Pre-School:
12 Children : 1 Teacher

BFTS Pre-K:
11 Children : 1 Teacher

Pre-K Before /After School:
12 Children : 1 Teacher

CYP SPONSOR HANDBOOK:

To view all other operating guidelines please refer to your CYP Sponsor Handbook which may be accessed at www.mccsalbany.com

To access this document, click on the Family Care tab, followed by the Child and Youth Programs tab. Once you have reached this page you will find a link to our most updated CYP Sponsor Handbook.

CHILD DEVELOPMENT CENTER FEE POLICIES AND SCHEDULE

- Before and After School Fees are applied only during the School Year.
- There is a $5.00 charge to replace lost or damaged CYMS access cards.
- Gross income (before taxes) includes BAH and BAS.
- MCLB Albany reserves the right to collect fees if patrons accounts become delinquent.
- 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.)
- An annual, non-refundable **$35.00 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.
- **Gross Total Family Income*** includes all members of the household regardless of marital status. If patrons do not disclose income of all members of the household, they may be subjected to investigation and possible removal from Child and Youth Programs.

Category	Gross Total Family Income*	Full-Time Care	Full-Time Multi-Child Discount
I	$0 - $31,171	$127	$114
II	$31,172 - $37,848	$160	$144
III	$37,849 - $48,980	$197	$177
IV	$48,981 - $61,224	$229	$206
V	$61,225 - $77,924	$264	$238
VI	$77,925 - $90,116	$288	$259
VII	$90,117 - $106,018	$296	$266
VIII	$106,019 - $132,569	$307	$276
IX	$132,570 +	$318	$286
IX CTR	$132,570 +	$447	$402

Standard Hourly Drop In Care Rate for eligible age groups is $4.

PART-DAY FEES

Category	Gross Total Family Income*	3-Day 0800-1200 Pre-Toddler/Toddler/ Preschool	2- Day 0800-1200 Pre-Toddler/Toddler/ Preschool
I	$0 - $31,171	$36	$25
II	$31,172 - $37,848	$45	$32
III	$37,849 - $48,980	$55	$39
IV	$48,981 - $61,224	$64	$46
V	$61,225 - $77,924	$74	$53
VI	$77,925 - $90,116	$81	$58
VII	$90,117 - $106,018	$83	$59
VIII	$106,019 - $132,569	$86	$61
IX	$132,570 +	$89	$64
IX CTR	$132,570 +	$125	$89

BEFORE & AFTER CARE FEES

Category	Gross Total Family Income*	Before School	After School	Before & After School
I	$0 - $31,171	$13	$45	$58
II	$31,172 - $37,848	$16	$56	$72
III	$37,849 - $48,980	$20	$69	$89
IV	$48,981 - $61,224	$23	$80	$103
V	$61,225 - $77,924	$26	$93	$119
VI	$77,925 - $90,116	$29	$101	$130
VII	$90,117 - $106,018	$30	$104	$134
VIII	$106,019 - $132,569	$31	$108	$138
IX	$132,570 +	$32	$111	$143
IX CTR	$132,570 +	$45	$156	$201

CHILD & FAMILY QUESTIONNAIRE

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 other CYP Staff.

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? If so, when?

_____

- 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?

_____

_____

- Select the following mannerisms which could best describe your child:

__Impulsive	__Resilient	__Tenacious
__Self-controlled	__Free Spirited	__Confident
__Inquisitive	__Disagreeable	__Adventurous
__Independent	__Calm	__Cheerful
__Enthusiastic	__Assertive	__Shy
__Dependent	__Attentive	__Outspoken
__Sociable	__Energetic	__Patient
__Pleasant	__Inattentive	

These answers will help us learn more about your child so that we can properly plan for his or her development!

- Children are occasionally photographed while in their classrooms or on campus. These photographs may be used in classroom activities, child portfolios, and/or our newsletter. Occasionally media sources video or photograph our students during special events as well which may be posted on the installation and/or MCCS Albany website and Facebook pages. ***Do you grant, without limitation, permission for the use of any photographs of your child in any printed or online material for CYP.*** ◯ *Yes* ◯ *No*

_____

Parent(s)/Guardian(s) Signature Date

NAVMC 11903 (09-13) (EF)
FOUO - Privacy sensitive when filled in.

Print Form

U.S. Marine Corps Children, Youth & Teen Programs Registration Form

Date:

Privacy Act Statement:

AUTHORITY: 10 U.S.C. § 5013; 10 U.S.C. § 5041; and Marine Corps Order P1710.30E.
PRINCIPAL PURPOSE: This System of Records is governed by Privacy Act System of Records Notice NM01754-3 which can be downloaded at http://dpclo.defense.gov/privacy/SORNs/component/navy/NM01754-3.html. Information provided is used by USMC personnel to obtain information on authorized Children, Youth and Teens Program (CYTP) patrons for purposes of registration, and parent/guardian and emergency contacts.
RETENTION AND SAFEGUARDING: The information collected in this System will be maintained in paper and networked databases using password controlled systems and access to files based on a predefined need to know. Records are kept for two years after individual is no longer in CYTP and then destroyed by authorized disposal.
ROUTINE USES: In addition to those disclosures generally permitted under the Privacy Act of 1974, to various officials outside the Department of Defense (DoD) specifically identified in Privacy Act System of Records notice NM01754-3, and pursuant to the blanket routine uses established by DoD that apply to all DoD Privacy Act Systems of Records and posted at http://privacy.defense.gov/blanket_uses.shtml.
DISCLOSURE: Information is voluntary; however, if information is not provided, individuals may not be able to participate in CYTP activities.

Sponsor First Name:	Command/Unit/Employer:
Sponsor Last Name:	Wk Ph: / Extension:
Address 1:	Email:
Address 2:	Status: ☐ Active ☐ Reservist ☐ Retired MII Grade
City/State/Zip Code:	Branch: ☐ Marine Corps ☐ Navy MII Rank: ☐ Air Force ☐ Army ☐ DoD Civilian ☐ Other
Home Phone (with area code):	☐ Single Military ☐ Dual Military ☐ N/A ☐ Single Civilian ☐ Dual Civilian
Cell Phone (with area code):	Housing: ☐ On Base ☐ Off Base

SPOUSE / GUARDIAN

Spouse First Name:	Command/Unit/Employer:
Spouse Last Name:	Wk Ph: / Extension:
Address 1: (if different from above)	Email:
Address 2:	Status: ☐ Active ☐ Reservist ☐ Retired MII Grade
City/State/Zip Code:	Branch: ☐ Marine Corps ☐ Navy MII Rank: ☐ Air Force ☐ Army ☐ DoD Civilian ☐ Other
Home Phone (with area code):	Cell Phone (with area code):

LOCAL EMERGENCY CONTACT / RELEASE DESIGNEES

Name (first, last)	Address (include City/State/Zip Code)	Home Phone (with area code)	Cell Phone (with area code)	Relationship to Child

Reset Form

FOR OFFICIAL USE ONLY

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CYTP INFORMATION

Child/Youth/Teen 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 (Age 6-12)	☐ Teen Program (Age 13-18)	☐ Other: _____	☐ Off Base Family Child Care

Child/Youth/Teen 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 (Age 6-12)	☐ Teen Program (Age 13-18)	☐ Other: _____	☐ Off Base Family Child Care

Please answer the following questions by adding your initials in 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".		
SAC/Youth/Teens - I give my permission for youth/teen to use supervised computers and internet.		
I have received two CYMS cards per child.		

Parent/Guardian Signature	Date

For office use only

Registration Fee:	Amt:	Receipt #:	Amount Paid:	Paid on:	Rcvd by:

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

FOR OFFICE USE ONLY

FT, PD, DI, BF, AFT, CAMP AD, CIV, CTR, RESRV, RET

Classroom_____ Rcvd By_____

____ MCC.com ____CYMS ____FCP needed R&R _____

____Orientation ____ IAT needed ____Pre-K

Reset Form

FOR OFFICIAL USE ONLY

Adobe LiveCycle Designer 9

POLICIES & PROCEDURES FOR CYP (1 of 3)

PRIVACY POLICY: AUTHORITY:5 U.S.C. Sec 301

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

- Determination of those dependents eligible to be placed in the Child Development Center or School Age Care program maintained by the Marine Corps Logistics Base, Albany, Georgia.
- To provide information to the CYP personnel on any health problem of your child, or youth and to have necessary information on file to contact parents in case of emergency.
- 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 CYP facilities.

INITIAL:_____

Updating Emergency Information: It is important that our staff maintain current and accurate records for each child so that parents can be contacted in the event of an emergency. It is the parent's responsibility to make sure that the CYP has current contact information. If there are any changes to this information, the office must be notified promptly so that they can update their records. All contact information and/or permission to release your child to other adults is required in writing, prior to pick up. **INITIAL:_____**

Discipline Policy: Only managers, direct care staff, or teachers may discipline children. The discipline policy of the CYP is designed to help the child develop self-control, self-esteem, and a respect for the rights of others. In all cases, CYP Staff will give positive guidance, allow for redirection, and set clear behavior limits. In no case will any humiliating or frightening punishment be used to discipline a child. Only acceptable guidance techniques will be utilized to including talking with a 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 CYP facilities. Documentation of such incorrigible behavior, as well as any notification to the parents, is essential. Behavior will be handled on a case by case basis.

Child and Youth Program personnel will not exceed these acceptable techniques. To do so could result in the termination of their employment. Child and Youth 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, Family Care Branch Director or Marine and Family Services Family Advocacy Program Manager.

INITIAL:_____

POLICIES & PROCEDURES FOR CYP (2 of 3)

Absentee Policy: Full Payment of tuition is required on the 1st and 15th of each month, whether or not the child attends school each week. There is no absentee credit when school is missed because of holidays, illness, or for any other reason. There is one exception which is our vacation week.

INITIAL:_____

Vacation Week: Patrons will receive one "vacation" week per child per fiscal year. To use this week, the patrons account must show a zero balance owed to the CDC prior to redeeming. Patrons must also give the CDC two-weeks notice before taking this vacation. To receive the pro-rated amount students must not be in attendance at the CDC during this week. **INITIAL:_____**

Withdrawal Policy: *Upon withdrawal from our facilities patrons must provide a minimum of two weeks notice.* Tuition will continue to be due for this period. All outstanding balances must be paid in full once the withdrawal notice has been given. Any remaining balances must be paid within three days of withdrawal notice.

INITIAL:_____

Touch Policy: The CYP 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.

INITIAL:_____

Medical Care: 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.

Preferred Hospital_____ **INITIAL:_____**

Vaccine Policy: Vaccine documentation is required for all children receiving care at the CDC. Vaccine documentation must be on the Georgia form (GRITS 3231) and submitted at time of enrollment and whenever the record is updated. The influenza vaccine (Flu Shot) is required for all registered children.

INITIAL:_____

Health Assessment Policy: A Health Assessment (NAVMC 11902) is required for all children receiving care at the CDC. This document must be signed by a health care provider and submitted prior to the child receiving a start date. This form expires a year from date signed by doctor. Existing patrons are required to maintain a current Health Assessment.

INITIAL:_____

POLICIES & PROCEDURES FOR CYP (3 of 3)

Payment Policy: Accounts are billed on the 1st and 15th of the month. Automatic payment is highly encouraged and can be established by completing an "Automatic Payment Agreement." Credit card information provided will be secured and charged according to the Automatic Payment Agreement. Patrons are responsible to update form if there are any changes. If you opt not to use automatic payment option, fees are still due in full on the 1st and 15th of each month.

Payment is considered late on the 2nd and 16th of each month (Partial payments will NOT be accepted.) A charge of $6 per day will be applied to delinquent accounts. If the balance due, including late fees, is not paid in full by five working days after the fifth day, services are terminated on the fifth day of no payment. Services will be termination and late charges applied to account.

Accounts with outstanding balances will be turned over to the finance office for collection.

INITIAL:_____

Media Release Policy: Children are occasionally photographed while in their classrooms or on campus. These photographs may be used in classroom activities, child portfolios, and/or our newsletter. Occasionally media sources video or photograph our students during special events as well which may be posted on the installation and/or MCCS Albany website and Facebook pages. You hereby grant, without limitation, permission for the use of any photographs of your child in any printed or online material for CYP. You may initial to accept, or check here to decline the publication of your child's photograph.

☐ **DECLINE CYP MEDIA RELEASE** **INITIAL:_____**

To view the full policy and all other operating guidelines please refer to your Sponsor Handbook which may be accessed at www.mccsalbany.com. To access, click on the Family Care tab, followed by the Child and Youth Programs tab. On this tab you will find a link to our most updated CYP Sponsor Handbook.

INITIAL:_____

Child Abuse: Doesn't Report Itself

If you see or suspect child abuse, child neglect or a safety violation in your DoD Child and Youth Programs, please contact the following:

Family Advocacy Program: (229) 639-5252

PMO: (229) 639-5181

DoD Child Abuse & Safety Violation Hotline: (877) 790-1197

CONTRACT FOR SERVICES

I, the parent or legal guardian of _____, contract the following service for my child's care.

Check one box:

☐ Full-Time Care ☐ Pre-K Before Care

☐ Drop-In Care ☐ Pre-K After Care

☐ Tuesdays & Thursdays Pre-Toddler/ Toddler/Pre-School **8am-12pm**

☐ Mondays, Wednesdays, & Fridays Pre-Toddler/Toddler/Pre-School **8am-12pm**

☐ Bright from the Start Pre-K Program

* Patrons using Drop-in care must give notice of attendance the Friday prior to receiving services. Emergency situations will be handled on a case by case basis by Management.

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 prior to receiving services. Any accounts with outstanding balances will be forwarded to MCCS Accounting for collections.

Late Pick-Up Fees- the CDC closes promptly at 6:00 pm. Children at the CDC after 6:00 pm will initially be charged $5.00. 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 no later than 6:00 pm.

I have read and fully agree to abide by the outlined Operating Guidelines and Service Contract concerning my obligations to the MCLB Albany Child Development Center.

X

_____

Parent(s)/Guardian(s) Signature **Date**

APPLICATION FOR DOD CHILD CARE FEES

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. YEARS OF MILITARY/CIVIL SERVICE
c. 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. YEARS OF MILITARY/CIVIL SERVICE
c. 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

DD FORM 2652, JUN 2009 PREVIOUS EDITION IS OBSOLETE. Reset Adobe Professional 8.0

CHILD & ADULT CARE FOOD PROGRAM (CACFP)

UNITED STATES MARINE CORPS
Marine Corps Logistics Base
Child Youth Programs
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. **MCLB Albany Children Youth and Teen Programs** 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: MCLB Albany Children Youth and Teen Programs. 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 additional questions or need help, call 229-639-5269 or 229-639- 5481.

CACFP INCOME ELIGIBILITY STATEMENT CONTINUED

Household Size	Yearly Income
1	$21,978
2	$29,637
3	$37,296
4	$44,955
5	$52,614
6	$60,273
7	$67,951
8	$75,647
Each additional person	Add: $7,696

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.

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 U.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 USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice).

Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

USDA is an equal opportunity provider and employer.

CACFP INCOME ELIGIBILITY STATEMENT 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 **(229) 639-5765.**
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.

If your children qualify for free or reduced price meals, they may also be able to get free or low cost health insurance!

CACFP INCOME ELIGIBILITY STATEMENT

PART I: Child(ren) 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	Foster Child

PART II A: **Name** (List everyone in household, including foster and non-foster children)	**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**	**3. Social Security, pensions, retirement**	**4. All other income**	
1._____	$_____/____	$_____/____	$_____/____	$_____/____	
2._____	$_____/____	$_____/____	$_____/____	$_____/____	
3._____	$_____/____	$_____/____	$_____/____	$_____/____	
4._____	$_____/____	$_____/____	$_____/____	$_____/____	
5._____	$_____/____	$_____/____	$_____/____	$_____/____	
6._____	$_____/____	$_____/____	$_____/____	$_____/____	
7._____	$_____/____	$_____/____	$_____/____	$_____/____	

PART III: 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 II 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. This signature also acknowledges that the child(ren) listed on the form in Part I are enrolled for care .*

Signature: X_____ **Print Name**_____

Date_____

Address: _____ ___ **City** _____ **State: GA**

Zip_____ **Phone** _____

Last four Digits of Social Security Number XXX-XX_____ ☐ I do not have a Social Security Number

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

Mark one ethnic identity: Hispanic/ Latino Not Hispanic/ Latino	Mark one or more racial identities: 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_____

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 MCLB Albany Child and Youth Programs, 814 Radford Blvd., Suite 20311 Albany, GA 31704. (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: _____

October 2008

CACFP Meal Benefit Income Eligibility Form Sharing Information with Medicaid/SCHI

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

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

YOU DO NOT HAVE TO BE ON PUBLIC ASSISTANCE TO APPLY.
CALL YOUR LOCAL HEALTH DEPARTMENT FOR MORE INFORMATION.

http://wic.ga.gov

INTERACTIVE CUSTOMER EVALUATION : ICE

The Interactive Customer Evaluation (ICE) system is a web-based tool that collects feedback on the services provided by various organizations throughout the Department of Defense (DoD.) The ICE system allows customers to submit online comment cards to rate the service providers that have encountered at the military installations and related facilities around the world. It is designed to improve customer service by allowing managers to monitor the satisfaction levels of services provided through reports and customer comments.

http://ice.disa.mil

- DoD based customer feedback system that addresses concerns within the facilities and activities here at MCLB Albany
- Your opportunity to voice any concerns, "the good" or "the bad"
- Suggest how you would like a situation addressed and/or program changed
- Provides prompt, up to date information flow between management and customers
- No suggestion boxes or extended waits for resolutions
- Useful tool to encourage members of the MCLB Albany team with praise reports

Please visit the website to leave a comment regarding any of our programs!

MARINE & FAMILY LIFE CONSULTANT CONSENT FORM

MEMORANDUM FOR: Parents/Guardians of Child Development Center and School Age Care students
FROM: MCLB ALBANY CYP
SUBJECT: Child and Youth Behavioral Military & Family Life Counselor (CYB-MFLC)

1. Due to the unique challenges faced by military families, particularly during this time of war, the Department of Defense is providing professional licensed counseling staff to provide non-medical counseling services to Service members and their families, children and staff of MCLB ALBANY CYP. This letter is to inform you about the Child and Youth Behavioral Military & Family Life Counselor (CYB-MFLC) Program.

2. With the exception of mandatory state, federal, and military reporting requirements (i.e., domestic violence, child abuse, and duty to warn situations) MFLC support is private and confidential to encourage the widest level of participation.

3. The CYB-MFLCs are available to provide non-medical support to faculty, staff, parents, and children for issues amenable to short-term problem resolution such as school adjustment issues, deployment and reunion adjustments, and parent-child communications. In his/her role as a counselor, he/she is available to:
   - Observe, participate, and engage in activities with children and youth
   - Outreach to parents
   - Facilitate deployment groups at the school
   - Conduct trainings for staff and parents

   Recommend referrals to military social services and other local resources as needed

Subject areas may include, but are not limited to the following:

- Communication
- Resolving conflicts techniques
- Managing anger
- Bullying
- Self-esteem/Self-confidence
- Behavioral management
- Sibling/parental relationships
- Deployment and reintegration issues

The counselor may also work with children in settings such as field trips and other school sponsored activities where he/she is available to talk to the children, facilitate group activities and be involved in such a way as to enhance the children's experiences.

The counselor is available to accommodate appointments and meetings/activities after hours and on the weekend with advance notice.

Please note the following rule that our counselor must abide by:

At no time will the counselor meet individually with a child without being in line of sight of a school employee or their parent/guardian.

The school is very excited to offer the Child and Youth Behavioral Military & Family Life Counselor program; a confidential program which is offered at no cost. If you have questions regarding this support offering, please feel free to call: CDC Director at 229-639-5765. If you would like a call from the MFLC, please initial here_____.

Please complete the permission section below and return to the school.

I acknowledge that a CYB-MFLC is available and **authorize** my child, _____, to receive CYB-MFLC support.

Parent or Guardian Signature X_____

I acknowledge that a CYB-MFLC is available and **DO NOT** authorize my child, _____, to receive CYB-MFLC support.

Parent or Guardian Signature X_____

NAVMC 11902 (09-13) (EF)
FOUO - Privacy sensitive when filled in.

Print Form

U.S. Marine Corps Children, Youth & Teen Programs (CYTP) Health Assessment

Privacy Act Statement:

AUTHORITY: 10 U.S.C. § 5013; 10 U.S.C. § 5041; and Marine Corps Order P1710.30E. **PRINCIPAL PURPOSE:** This System of Records is governed by Privacy Act System of Records Notice NM01754-3 which can be downloaded at http://dpclo.defense.gov/privacy/SORNs/component/navy/NM01754-3.html. Information provided is used by USMC personnel to: (1) verify child required immunizations per admission requirements; (2)be used by the Inclusion Action Team to determine necessary and appropriate accommodations in CYTP activities.; (3) execute emergency medical procedure for chronic illnesses/conditions; (4) refer child for enrollment in Exceptional Family Member Program; and (5) determine if at time of enrollment child is physically fit to participate in USMC CYTP programs. **ROUTINE USES:** In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, to various officials outside the Department of Defense (DoD) specifically identified in Privacy Act System of Records notice NM01754-3, and pursuant to the blanket routine uses established by DoD that apply to all DoD Privacy Act Systems of Records and posted at http://privacy.defense.gov/blanket_uses.shtml. **DISCLOSURE:** Information is voluntary; however, if information is not provided, individuals may not be able to participate in CYTP activities.

SPONSOR INFORMATION (please print)

Name of Sponsor	Sponsor Unit

Home Phone	Cell Phone	Duty/Work Phone

CHILD/YOUTH INFORMATION (please print)

Name of Child/Youth	Birth Date			Enrolled in Public School		
		Male	Female		Yes	No

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

1. Any hospitalization or operations		14. Heat stroke or exhaustion	
2. Allergies to medicine, insect bites, latex or food (please explain reactions)		15. Broken bones or sprains	
3. Development delays/Learning problems		16. Joint injuries	
4. Eye or vision Problems (Glasses/Contacts)		17. Restricted physical activity	
5. Ear or hearing problems		18. Diabetes	
6. Seizures or Convulsions		19. Cancer	
7. Dizziness or fainting with exercise		20. Dental	
8. Headaches		21. Mental Health Issues	
9. Head injury or loss of consciousness		22. Sleep problems	
10. Neck or back injury		23. Behavioral problems	
11. Asthma or difficulty breathing		24. ADD/ADHD	
12. Heart or blood pressure problems		25. Benign skin colorations (e.g., birthmarks)	
13. Chest pain with exercise		26. Other problems	

If any apply, please explain

Is the child/youth enrolled in Exceptional Family Member Program? (Specify what branch of Service) Yes No	Has your child been seen by a Health Care provider regarding their Special Need within the last year? Yes No
Does the child/youth have any special needs/considerations (including religious/cultural)? Yes No * If there are special considerations, a Health Screening Tool for Inclusion Action Team will need to be completed by the healthcare provider.	Does the child/youth have ongoing medical concerns? (If Yes, explain circumstances and current status) Yes No

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

Height:	Weight:	BP:	HR:

	Normal	Abnormal	N/A		Normal	Abnormal	N/A
1. Eyes				8. Chest/Abdomen			
2. ENT				9. Genitalia			
3. Hearing				10. Skin			
4. Mouth/Teeth				11. Lymphatic			
5. Neck				12. Spine			
6. Cardiovascular				13. Extremities			
7. Respiratory				14. Neurological			

Based on this examination, the following abnormalities were found and may need treatment

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.

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

Date	Parent/Guardian Signature	Health Care Provider Stamp or Printed Name & Address
Date	Health Care Provider Signature	

Reset Form

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U.S. Marine Corps Children, Youth & Teen Programs (CYTP) Health Assessment
Health Screening Tool for Inclusion Action Team (IAT)

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

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

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) ☐

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

Medication

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

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

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

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

Name	Dosage	Frequency	During Child Care
			☐
			☐
			☐

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

Dietary modifications? ☐ No ☐ Yes (explain)

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

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

Carry and Self-Administer Authorization (to be completed by health care provider)

☐ **N/A**

☐ **YES** 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.

☐ **NO** 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.

Health Care Provider or Specialist Signature	Date	Health Care Provider Stamp or Printed Name & Address

Phone	Email

Early Intervention and Special Education

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

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

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.

Parent/Guardian Signature	Date

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

Signature	Date	IAT Meeting date if required

Reset Form

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Print Form

U.S. Marine Corps Children, Youth & Teen Programs What to bring to Resource and Referral (R&R)	
Contact local R & R to set up an appointment to complete the registration package. To expedite the registration process, please have the following information available:	
Parent Information Needed	
Complete Home Address (indicate if housing is on or off base)	
Complete Work Address	
Military Command/Unit (Branch of Service)	
Spouse/Guardian Work Address and Employer's Name	
Home, Work and Cell Phone numbers for yourself and spouse/ guardian.	
Email for yourself and spouse/guardian that is accessible during work hours.	
Current Leave and Earnings Statement (LES) for yourself and spouse. If spouse is a full time student bring proof of school enrollment (This information is used to determine DOD Fee Category).	
Local emergency contacts for children and youth (other than parents). Full name and phone numbers are required.	
What type of care or service are you requesting?	
Child/Youth Information Needed	
Proof of DEERS	
Child/Youth Official Shot Records	
Current Child/Youth Health Assessment	
Health Screening Tool for Inclusion Action Team (IAT) (If applicable)	
Child/Youth School and Grade	
Forms to complete and bring with you to your appointment	
USDA Income Eligibility Form	
Family Care Plan (If applicable)	

Reset Form

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