USMC CHILD AND YOUTH PROGRAMS REGISTRATION FORM

OMB No. 0703-0068

OMB Approval Expires 09/30/2025

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), this notice informs you of the purpose for collection of information on this form. Please read it before completing the form.

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 and Youth Programs (CYP) for purposes of patron registration in CYP programs and activities and parent/guardian and emergency contacts.
ROUTINE USES: Information will be accessed by CYP personnel with a need to know to meet the purpose. Information is not routinely disclosed outside of DoD. 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. A complete list and explanation of the applicable routine uses are published in the authorizing SORNs available at: https://dpcld.defense.gov/Privacy/SORNsIndex/DODwide-SORN-Article-View/Article/570428/nm01754-3/.
DISCLOSURE: Information is voluntary; however, failure to provide information may adversely impact individuals from participation in CYP activities.
RECORD MANAGEMENT: This form shall be managed in accordance with record schedule 1000-39, "Family Support Programs (Temporary)" of SECNAV M-5210.1.

The public reporting burden for this collection of information, OMB No. 0703-0068, is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any burden reduction suggestions to the Department of Defense, Washington Headquarters Services, at whs.mc-alex.esd.mbx.dd-dod-information-collections@mail.mil. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR RESPONSE TO THE ABOVE ADDRESS. Responses should be sent to your Regional Director.

INSTRUCTIONS FOR COMPLETING NAVMC 1750/5

GENERAL
This form is completed by the parent/legal guardian or custodian, or Agent acting pursuant to a power of attorney. Information provided is used by Child and Youth Programs (CYP) for purposes of participant registration in CYP programs and activities. At least annually or when the information is outdated a new form will be completed, signed, and dated.

SPONSOR INFORMATION
Items 1-3. Self-explanatory.
Item 4. Indicate Sponsor's status in the military.
Item 5. If applicable, indicate Sponsor's military grade, otherwise type "N/A".
Item 6. Indicate branch Sponsor is affiliated with.
Items 7-10. Self-explanatory.
Item 10a. Name of cell phone carrier.

SPOUSE / GUARDIAN INFORMATION
Items 11-20a. Please follow instructions for items 1-10a above as it relates to the spouse / guardian.

CHILD / YOUTH INFORMATION
Items 21-23. Self-explanatory. There are three sections provided on the form if the family is registering multiple participants. Please fill in one section for each participant.
Item 24. Answer Yes if use of video and photographs are allowed. Otherwise, answer No.
Answer Yes if participant is allowed to attend field trips. Otherwise, answer No.
Answer Yes if you received the Parent Handbook. Otherwise, answer No.
Answer Yes if participant is allowed to use computers and internet. Otherwise, answer No.
Answer Yes if you are aware of the DoD Priority Supplanting Policy. Otherwise, answer No.

LOCAL EMERGENCY CONTACT / RELEASE DESIGNEES
Items 25-28. Self-explanatory. These individuals will be contacted when the parents/guardians are unavailable and also have permission to depart the premises with the participant. There are three rows for multiple emergency contacts/release designees. Fill out one row for each emergency contact/ release designee.
Item 29. Provide the relationship that the emergency contact/release designee has with the participant.
Items 30-31. Self-explanatory.

SPONSOR INFORMATION			
1. Name (First MI Last):			
2. Address:			
3. Command/Unit/Employer:			
4. Military Status:	5. Military Grade:	6. Branch:	7. Email:
8. Home Phone:		9. Work Phone:	
10. Cell Phone:		10a. Cell Carrier:	

SPOUSE / GUARDIAN INFORMATION			
11. Name (First MI Last):			
12. Address:			
13. Command/Unit/Employer:			
13a. Full-time Student Post-Secondary Institution? ◯ Yes ◯ No			
14. Military Status:	15. Military Grade:	16. Branch:	17. Email:
18. Home Phone:		19. Work Phone:	
20. Cell Phone:		20a. Cell Carrier:	

CHILD / YOUTH INFORMATION		
21. Child 1 First and Last Name:		Nick Name:
Gender:	Birthdate:	School Grade (K-12 or N/A):
Program Enrollment: ◯ Full Day ◯ Part Day ◯ Hourly ◯ Family Child Care ◯ School Age Care (BF/AF) ◯ School Age Care (BF) ◯ School Age Care (AF) ◯ Summer Camp ◯ Youth and Teen Program ◯ Other:		
22. Child 2 First and Last Name:		Nick Name:
Gender:	Birthdate:	School Grade (K-12 or N/A):
Program Enrollment: ◯ Full Day ◯ Part Day ◯ Hourly ◯ Family Child Care ◯ School Age Care (BF/AF) ◯ School Age Care (BF) ◯ School Age Care (AF) ◯ Summer Camp ◯ Youth and Teen Program ◯ Other:		
23. Child 3 First and Last Name:		Nick Name:
Gender:	Birthdate:	School Grade (K-12 or N/A):
Program Enrollment: ◯ Full Day ◯ Part Day ◯ Hourly ◯ Family Child Care ◯ School Age Care (BF/AF) ◯ School Age Care (BF) ◯ School Age Care (AF) ◯ Summer Camp ◯ Youth and Teen Program ◯ Other:		

24. Please answer the following questions by marking either Yes or No:

I allow use of video and photographs of my child within the CYP program.	◯ Yes ◯ No	I give my permission for child to use supervised computers and internet.	◯ Yes ◯ No
I approve my child/youth to attend field trips.	◯ Yes ◯ No	I am aware of the DoD Priority Supplanting Policy	◯ Yes ◯ No
I have received a copy or was given the website on where to get a "Parent Handbook".	◯ Yes ◯ No		

LOCAL EMERGENCY CONTACT / RELEASE DESIGNEES (*minimum of three contacts required*)

25. Name (First MI Last)	26. Address	27. Home Phone	28. Cell Phone	29. Relation to Child

30. Parent/Guardian Signature:	31. Date:

CHILD AND YOUTH PROGRAMS
SPECIAL NEEDS SCREENING FORM

Purpose: To provide child and family program eligibility and background information; to assist with child's placement and obtain sponsor consent for access to emergency medical care; data required by the Exceptional Family Member Program. Policies shall be implemented to ensure that appropriate services are provided for children, youth, and teens with special needs. Such policies shall meet the requirement of the Rehabilitation Acts and the Department of Defense Directive 1020.1, Non Discrimination on the Basis of Handicap in Programs and Activities Assisted or Conducted by the Department of Defense.

Routine Uses: This information will be shared with members of the Inclusion Action Team (IAT) to assist with making an informed decision about your child's placement. Information is used for program admission to ensure staff training is pertinent to the child's needs. Information is furnished for the attending physician when it is necessary for a child to be taken to a medical facility by someone other than the parent.

Disclosure: Disclosure of information is voluntary; however, if information is not provided, individuals may not be allowed to participate in Child and Youth Programs.

Child's Name: ______________________________ DOB: ______________

Sponsor's Name: ____

Routine Medication(s) taken consistently of the past 6 months: ______________________

Required Special Care or Service(s): ______________________________

Is child enrolled in the Exceptional Family Member Program (EFMP) (please circle) YES ☐ NO ☐

PLEASE CHECK ALL THAT APPLY IF YOUR CHILD HAS BEEN DIAGNOSED WITH ANY OF THE FOLLOWING MEDICAL OR DEVELOPMENTAL CONDITIONS

My child has **NO** special needs or diagnosed condition(s)

Check	Special Needs/Conditions	Comments
☐	*Allergy – Food/ Medication	
☐	*Allergy – Environmental/Insect	
☐	ADD/ADHD	
☐	*Asthma or RAD	
☐	Autism/Pervasive Developmental Disorder	
☐	Behavior Concerns (ODD, etc)/ Psychological Concerns: (Depression, OCD)	
☐	Developmental Delays/ Speech Delays	
☐	Epilepsy/ Seizures	
☐	Medical Equipment Needs (G-tube, tracheotomy, Wheelchair, etc)	
☐	Genetic Disorder (please list):	
☐	Other (please list):	

***PHYSICIAN SIGNED DOCUMENTATION WILL BE REQUIRED PRIOR TO START DATE.**

USMC CHILD AND YOUTH PROGRAMS HEALTH ASSESSMENT

OMB No. 0703-0068
OMB Approval Expires 09/30/2025

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PURPOSE: The information collected on this form is used by Child & Youth Programs (CYP) and Inclusion Action Team personnel to determine the general health status of patrons participating in CYP activities and if necessary the appropriate accommodations for the patron for full enjoyment of CYP services.
ROUTINE USES: Information will be accessed by CYP personnel with a need to know to meet the purpose. Information may be disclosed to health care providers. Any release of information contained in this system of records outside of DoD will be compatible with the purposes for which the information collected and maintained. A complete list and explanation of the applicable routine uses are published in the authorizing SORN available at:https://dpcld.defense.gov/Privacy/SORNsIndex/DODwide-SORN-Article-View/Article/570428/nm01754-3/.
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GENERAL INFORMATION (please print) Pages 1 and 2 to be completed by Parent/Guardian

1. Sponsor Name (Last, First): | 2. Sponsor Phone Number:

3. Participant Name (Last, First):

4. Date of Birth: | 5. Gender: | 6. Enrolled in Public School: ◯ Yes ◯ No

IDENTIFICATION OF CHILD/YOUTH CONDITIONS AND ACCOMMODATIONS

7. The child/youth has the following (check all that apply):

◯ **N/A - Child/Youth does not have any identified needs, considerations or accommodation requirements**

◯ **Allergies (Attach Allergy Action Plan)**
Food Environmental Medicine Type of reaction: ◯ Anaphylaxis ◯ Local reaction (mild)
Other/Explain:

◯ **Asthma or Reactive Airway Disease (Attach Asthma Action Plan)**
Explain (triggers, controlled, medication required):

◯ **Behavioral or Emotional Needs (e.g., ADD, Autism, and ODD)**
Explain:

◯ **Developmental Delay or Needs**
Explain:

◯ **Diabetes (Attach Diabetes Care Plan)** ◯ Insulin dependent ◯ Non-insulin dependent
Explain:

◯ **Environmental Adaptations (e.g., room temperature and wheelchair access)**
Explain:

◯ **Needs Assistance with Activities of Daily Living**
Explain:

Participant Name (Last, First):	Date of Birth:

IDENTIFICATION OF CHILD/YOUTH CONDITIONS AND ACCOMMODATIONS *Continued*

◯ **Orthopedic Condition**

Explain:

◯ **Other Chronic Health Condition (e.g., bladder/bowel condition, cancer, and hemophilia)**

Explain:

◯ **Seizures (Attach Seizure Action Plan)** Type of seizure: ◯ Febrile ◯ Absent ◯ Epilepsy ◯ Other Seizure Disorder

Explain:

◯ **Skin conditions (e.g., rashes, eczema, discoloration, birth marks, and cloth diaper use)**

Explain:

◯ **Special Diet/Food Intolerance or Dietary Modifications**

Explain:

◯ **Speech/Communication Needs**

Explain:

◯ **Vision/Hearing Disability**

Explain:

◯ **Other (conditions/adaptations/modifications/recommendations/concerns or comments to ensure the child's/youth's needs are met)**

Explain:

8. Does your child require medication while participating in CYP? (If yes, a Medication Authorization must be completed)

◯ Yes ◯ No If yes, please list:

9. Has the child/youth required the care of a Health Care Provider for any ongoing health conditions or surgeries in the past year? ◯ Yes ◯ No

If yes, explain circumstances and current status:

10. Is the child/youth enrolled in Exceptional Family Member Program? ◯ Yes ◯ No If yes, what branch of Service?

11. Child has an: ◯ Individualized Family Service Plan (IFSP) ◯ Individualized Education Program ◯ 504 Plan ◯ Behavioral Plan ◯ None

If a plan is identified, what type of services does your child/youth receive (e.g. speech, physical, occupational, ABA)?

Will required services be provided by outside agencies (e.g., early intervention and school district) during care? ◯ Yes ◯ No

A current copy of the child/youth immunization record must be given to CYP.

PARENT/GUARDIAN SIGNATURE

I understand that all reasonable efforts will be made to support the needs documented on this health assessment. Each child's needs and required accommodations are considered on a case-by-case basis by a collaborative team at the program level. Some cases need the support of the Inclusion Action Team (IAT) to determine reasonable accommodations and identify additional resources. Parent/guardian(s) will be notified and invited to attend IAT meetings. I acknowledge that CYP is not responsible for providing the child/youth with services that would be considered skilled nursing or behavioral, occupational, speech, or physical therapy. I understand that this form must be updated annually, or earlier, if there is a change in condition or need.

12. Name (Last, First):	13. Signature:	14. Date:

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

15. Name (Last, First):	16. Signature:	17. Date:

Participant Name (Last, First):	Date of Birth:

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

18. Date of Physical Assessment:	19. Height:	20. Weight:	21. BP:	22. HR:

	Within Normal	Abnormal Finding	Not evaluated		Within Normal	Abnormal Finding	Not evaluated		Within Normal	Abnormal Finding	Not evaluated
23. HEENT				24. Neurological				25. Urinary			
26. Dental/Oral				27. Back/ Extremities				28. Abdomen			
29. Lungs				30. Skin				31. Heart			
32. Genital				33. Explain abnormal findings:							

34. Passed all age appropriate routine screenings: ◯ Yes ◯ No (if no, please explain **and note if referred to specialist)**

35. Immunizations are current and up to date: ◯ Yes ◯ No

Medical Exemption: I certify that administration of the below vaccine(s) would be detrimental to this child's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

This contraindication is ◯ permanent ◯ or temporary and expected to preclude immunizations until: Date (M/D/YYYY):

☐ CONDITIONAL EXEMPTION: This participant has received at least one dose of each of the vaccines required and has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on:

A current copy of the child/youth immunization record must be given to CYP.

MEDICATION (If more space is needed, please attach additional documents)

36. Ongoing medications prescribed for child/youth? ◯ Yes ◯ No — If Yes, list medications (including Emergency) below and indicate which require administration during child care hours.

37. Medication Name and Strength	38. Dosage	39. Frequency	40. Potential Side-Effects	41. Required during childcare
				☐
				☐
				☐
				☐
				☐
				☐

42. Carry and Self-Administer Authorization for School Age Care and Youth only (provider initials)

	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.

43. The child/youth is able to participate in CYP and appears to be free from contagious or communicable diseases. ◯ Yes ◯ No

If no, please explain:

44. Healthcare Provider Stamp or Printed Name & Address	45. Healthcare Provider Signature
	46. Date

APPLICATION FOR DEPARTMENT OF DEFENSE CHILD CARE FEES

(Read Instructions on back before completing form.)

OMB No. 0704-0515
OMB approval expires 20231031

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PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 3013, Secretary of the Army; 10 U.S.C. 5013, Secretary of the Navy; 10 U.S.C. 5041, Headquarters, Marine Corps; 10 U.S.C. 8013, Secretary of the Air Force; DoD Instruction 6060.02, Child Development Programs; Army Regulation 608-10, Child Development Services; OPNAV Instruction 1700.9E series, Child and Youth Programs; Marine Corps Order P1710.30E, Children, Youth, and Teen Program (CYTP); Air Force Instruction 34-144, Child and Youth Programs.

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

ROUTINE USE(S): Department of the Army records may be disclosed to civilian health and welfare departments/agencies in emergencies. Department of the Navy records may be disclosed to local, state and Federal officials involved in child care services, if required, in the performance of their official duties relating to child abuse reporting and investigations. Department of the Air Force records may be disclosed to civilian health and welfare departments/agencies in emergency situations.
Additional Routine Uses can be found in the SORNS: Department of the Army: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570083/a0608a-cfsc/; Department of the Navy: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570428/nm01754-3/; Department of the Air Force: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/569755/f034-af-sva-c/;

DISCLOSURE: Required. Failure to provide the required information will delay the processing and approval of child care services.

SECTION I - DEPENDENT CHILDREN

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

SECTION II - ANNUAL FAMILY INCOME

5. SPONSOR

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

c. INCOME

(1) Income Data	(2) Basic Allowance for Housing (BAH)	(3) Basic Subsistence Allowance	(4) Other Earned Income	(5) Total Income - Sponsor (To be completed by Program Staff)

6. SPOUSE OR OTHER ADULT LIVING IN THE HOME

a. NAME *(Last, First, Middle Initial)*	b. INCOME

7. OTHER INCOME EARNED	8. TOTAL INCOME *(Include income from Blocks 5, 6, and 7. To be completed by Program Staff.)*

SECTION III - CERTIFICATION OF SPONSOR/DESIGNEE

(Required for all categories. 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 misrepresentation 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)*

SECTION IV - FOR CHILD DEVELOPMENT PROGRAM USE ONLY

12. PRIORITY SYSTEM ELIGIBILITY	13. CATEGORY OF APPROVAL	14. AUTHORIZED FEES	15. DATE OF APPROVAL *(YYYYMMDD)*	16. NAME OF CHILD DEVELOPMENT PROGRAM OFFICIAL

INSTRUCTIONS

Per Department of Defense Instruction 6060.02, Child Development Programs, this form is utilized to determine fees for DoD Child Care Programs.

To determine child care fees for your child(ren), or and child(ren) you legally claim as dependents, this from must be completed, signed and returned to the facility for which your child is enrolling.

Fees are determined based on your Total Family Income (TFI) as defined below. TFI documentation is required for child care rate determination.

Total Family Income (TFI) - For the purpose of determining child care fees in DoD Child Development Programs, total family income is defined as all earned income including wages, salaries, tips, special duty pay (flight pay, active duty demo pay, sea pay) and active duty save pay, long-term disability benefits, voluntary salary deferrals, retirement or other pension income including SSI paid to the spouse and VA benefits paid to the surviving spouse before deductions for taxes. TFI calculations must also include quarters subsistence and other allowances appropriate for the rank and status of military or civilian personnel whether received in cash or in kind.

DO NOT INCLUDE alimony, and child support received by the custodial parent, SSI received on behalf of the dependent child, reimbursements for educational expenses or health and wellness benefits, cost of living (COLA) received in high cost areas, temporary duty allowances, or reenlistment bonuses.

For households in which unmarried couples or pairs are living as a family, the income for both adults should be used to determine Total Family Income (TFI).

Sections I, II, and III are to be completed by the sponsor or their designee.

Section I.

1. Provide the last name, first name and middle initial for each child who is receiving care in a DoD child care program.

2. Provide the date of birth for each child who is receiving care in a DoD child care program.

3. Provide the age of each child on the date of application who is receiving care in a DoD child care program.

4. Provide the type of care being request or in which each child is currently enrolled.

Section II.

When completing Section II, include all military and civilian income for both the sponsor and spouse or other adult living in the home.

5.a. Provide the sponsor's last name, first name and middle initial.

5.b. Provide the total years of military/civilian service as applicable.

5.c.(1) Provide your most recent income data and indicate if income is received weekly, biweekly, monthly or twice per month.

5.c.(2) Provide the current year BAH RT/C. For dual military living in government quarters include BAH RC/T of the senior member only; in locations where military members receive less than the BAH RC/T allowance, use the local BAH rate; for Defense civilian OCONUS include either the housing allowance or the value of the in-kind housing.

5.c.(3). Provide the basic subsistence allowance or in-kind equivalent.

5.c.(4) Provide any other earned income.

5.c.(5) To be completed by program staff.

6.a. Provide the last name, first name and middle initial of the spouse or other adult living in the home, who contributes to the welfare of the child.

6.b. Provide the income of the spouse or other adult living in the home, who contributes to the welfare of the child.

7. Provide any additional income.

8. To be completed by program staff.

Section III.

9. Provide the sponsor's signature.

10. Provide the spouse's or other resident adult's signature.

11. Provide the date of signatures.

Virginia Child and Adult Care Food Program (CACFP)
(Child) Annual Enrollment Form (AEF)

CENTER/PROVIDER COMPLETE THIS SECTION

☐ CDC North (3311)	☐ Youth Center (3312)	☐ CDC South (3314)

Center/Provider Name

Purvis Rd.	Quantico	VA	22134
Street Address	*City*	*State*	*Zip Code*

This institution participates in the Child and Adult Care Food Program (CACFP) and receives Federal reimbursement to provide nutritious meals for children. Federal CACFP regulations require all parents/guardians to complete and sign a separate Annual Enrollment Form for each child when enrolling their child(ren) with this provider, and every 12 months thereafter. **The parent or guardian must complete and ensure accuracy of Sections 1 through 6 below.**

This form is required for:	**This form is NOT required for:**
Child Care Centers, Family Day Care Homes	Outside School Hours Care Centers, Emergency Shelters

1 FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	2 DAYS OF WEEK IN ATTENDANCE	3 TIMES CHILD NORMALLY ATTENDS CARE DURING THE WEEK			4 MEALS RECEIVED
		TIME IN	TIME OUT	SPORADIC SCHEDULE (no set schedule of days)	
Child's First Name	☐ Monday ☐ Tuesday				☐ Breakfast ~~☐ AM Snack~~
Child's Last Name	☐ Wednesday ☐ Thursday				☐ Lunch ☐ PM Snack
Date of Birth (mm/dd/yyyy)	☐ Friday ☐ Saturday	NOTES:			~~☐ Supper~~ ~~☐ EV Snack~~
Age	☐ Sunday				

5 Parent/Guardian Signature and Date: ***By signing this form, I certify that I am the parent/legal guardian of the child named in Section 1 of this Annual Enrollment Form and that the information contained on this form is true and correct.***

Printed Name: *Signature:*

Street Address: *City, State, Zip Code:*

Phone Number HOME / WORK / CELL (circle one): *Date:*

Nondiscrimination 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.

6 Ethnic and Racial Identification: *Parent/Guardian to complete. Please select ONE Ethnicity; Please select ONE OR MORE Races*

ETHNIC IDENTIFICATION

○ **Hispanic , Latino or Spanish Origin:** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

○ **Not Hispanic, Latino or Spanish origin**

○ **I decline to answer.**

RACIAL IDENTIFICATION

○ **American Indian or Alaskan Native:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains culture identification through tribal affiliation or community attachment (includes Aleuts and Eskimos).

○ **Black, African American, or Haitian:** A person having origins in any of the black racial groups of Africa.

○ **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

○ **White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

○ **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

○ **I decline to answer.**

NOTES:

Information on this form must be kept confidential.

Child Care Representative Use Only

Effective Date of This Enrollment Form:	***The effective date may be retroactive to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.***
(mm/dd/yyyy)	
Effective Withdrawal Date of This Enrollment Form:	
(mm/dd/yyyy)	
Printed Name of Center Representative	***This form is effective for 12 months from the date of parent signature.***
Signature of Center Representative	

This institution is an equal opportunity provider.

VIRGINIA CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (IEF)FOR CHILD CARE CENTERS and FAMILY DAY CARE HOMES

1 All Household Members			2	3
NAMES OF ALL HOUSEHOLD MEMBERS [Adults and Children]			FOSTER CHILD	SNAP, TANF or FDPIR CASE #
First, Middle Initial, Last	Check if NO income	Ages of children in care	Skip to Part 6 if all are foster children.	Skip to Part 6 if you list a SNAP, TANF or FDPIR case number. SNAP AND TANF MUST BE NINE (9) DIGITS
1			☐	
2			☐	
3			☐	
4			☐	
5			☐	
6			☐	

4 Homeless, Migrant, or Runaway

☐ Homeless ☐ Migrant ☐ Runaway

If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call your School Homeless Liaison or Migrant Coordinator.

5 Total Household Gross Income (before deductions). You must tell us how much and how often.

NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	GROSS INCOME AND HOW OFTEN IT IS RECEIVED (Example: $100/month, $100/twice a month, $100/every other week, $100/week)							
	Earnings From Work		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Comp, Unemployment, SSI, etc.	
	Amount	How often	Amount	How often	Amount	How often	Amount	How often?
i.	$		$		$		$	
ii.	$		$		$		$	
iii.	$		$		$		$	
iv.	$		$		$		$	
v.	$		$		$		$	

6 Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Part 5 is completed or if zero income is listed, 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.

X X X – X X – ____________
Social Security Number

☐ **I do not have a social security number.**

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.

Date *Printed Name of Adult Household Member* *Signature of Adult Household Member*

7 Contact Information (Optional)

Work Telephone Number (Include Area Code) ( ) *Home Telephone Number (Include Area Code)* *Home Address (Number, Street, City, State, Zip Code)*

8 Optional - Sharing Information with Virginia's Health Insurance Program for Children (FAMIS)

May we share your information on this application with the *FAMIS* , the complete health insurance program for every child in Virginia? If **yes**, do not sign below.

☐ No, I do not want my information from this application shared with the FAMIS. Date:________________ Sign here: ________________________________

CHILD CARE REPRESENTATIVE USE ONLY – ELIGIBILITY DETERMINATION – COMPLETE SECTIONS A and B BELOW

SECTION A **Annual Income Conversion: Weekly X 52 Every 2 Weeks X 26 Twice a Month X 24 Once a Month X 12**

Convert income only if different frequencies of pay are reported.

TOTAL INCOME Per $____________ ☐ Week ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year **NUMBER IN HOUSEHOLD:** __________

☐ FREE based on:			☐ REDUCED based on:	☐ DENIED reason:	
☐ foster child	☐ migrant	☐ SNAP, TANF, FDPIR	☐ household income	☐ income too high	☐ incomplete application
☐ homeless	☐ runaway	☐ household income			☐ non-qualifying SNAP/TANF

SECTION B **Signature of Determining Official:**________________________________ **Date:** ____________________

Nondiscrimination 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.

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Quantico CYP Parent Handbook Acknowledgement Signature Page

I have read and understand the Parent Handbook. I acknowledge that I have read and understand the Standard Operating Procedures below, which are located in the CYP Parent Handbook and that I have received an orientation by the program.

Please place your initial next to each topic below:

__________ Child Abuse Reporting

__________Touch Policy

__________Intoxication Waiver

__________Biting Policy

__________Positive Guidance Policy

__________Staff to Child Ratio Guidelines

__________Payment Policy

__________Late Pick Up Policy/Fees

__________Mutual Respect Policy

__________Wellness Checks and Dismissals

In the event of a medical emergency, I consent for my child to be transported to the nearest hospital via an ambulance. I understand that if I am not present when the ambulance leaves the facility, a staff member at the program site will accompany my child to the hospital. I understand that the designated hospital is Stafford Hospital, although the hospital the child is routed to may change due to traffic and other situational circumstances.

____
Child Name

________________________________ ________________________________
Parent/Guardian Name Parent/Guardian Signature and Date

________________________________ ________________________________
Center Director Signature Date

Revised July 2022