Enrollment Packet Check List

FOR OFFICIAL USE ONLY- DO NOT FILL THIS SECTION OUT

CYS Information Update	
Vacation Policy and Initial Payment	
CYS USDA Letter	
Army CYS Health Screening Tool	
Sponsor's most recent full month Active Duty LES / One month's worth of most recent consecutive pay stubs	
Spouse's most recent full month Active Duty LES / One month's worth of most recent consecutive pay stubs	
Child(ren)'s Birth Certificate or DEERS Enrollment	
Child(ren)'s Current Shot Records **(All children 6wks-5yrs and K-5th in Private or Homeschool)**	

CYS Information Update
Please complete all information

Home Address _____

Sponsor Information

Full Name: _____
Cell Phone Number: _____
Unit/Employer, Phone Number: _____
Email address (work, personal): _____
Grade/Rank/Branch: _____

Spouse/Partner Information

Full Name: _____
Cell Phone Number: _____
Unit/Employer, Phone Number: _____
Email address (work, personal): _____
Grade/Rank/Branch: _____

Emergency Contacts (minimum of two)

Name, Phone number: _____
Allow pickup? Yes☐ No☐

Name, Phone number: _____
Allow pickup? Yes☐ No☐

Child's Information

Full Name: _____
DOB: _____ Grade 20/21 SY: ___ School: _____

Full Name: _____
DOB: _____ Grade 20/21 SY: ___ School: _____

Full Name: _____
DOB: _____ Grade 20/21 SY: ___ School: _____

Full Name: _____
DOB: _____ Grade 20/21 SY: ___ School: _____

Full Name: _____
DOB: _____ Grade 20/21 SY: ___ School: _____

Fort Meade Child & Youth Services
Vacation Policy and Initial Payment

Leave/Vacation options will **only be** available for children enrolled in Child Development Center (CDC) and Family Child Care (FCC) programs to include full day care and part day preschool.

Children enrolled in School Age Care (SACC) and Middle School/Teen (MST) **will not** receive vacation credits.

Patrons who are enrolled in CDC programs to include full day care and part day preschool will have the option to select either a two week or a four week vacation option. Fees of patrons who are enrolled in FCC programs reflect the two week vacation option only. The fee distribution for the two week and four week options are as follows:

A. Two week vacation option: Fees are evenly distributed across 50 weeks.

B. Four week vacation option: Fees are evenly distributed across 48 weeks.

Separate fee charts have been established to show the differences in cost. Under either option, patrons will not have to pay for services when the child(ren) is/are on vacation through their assigned program. Mandatory selection of one of the vacation options is required for all patrons during initial enrollment or re-registration for the upcoming year. Once a vacation option has been selected it cannot be changed until the next re-registration year, nor can it be transferred to another child. **Please note vacation cannot be used in lieu of termination. Patrons must provide a two week notification to the program to use vacation.** Vacation must be taken in a minimum increment of five consecutive work days.

Vacation Option

_____(Initial) I plan to use the 2 week vacation fee chart. ****FCC automatic two weeks**

_____(Initial) I plan to use the 4 week vacation fee chart

Initial Payment (CDC, SACC, MS Before Care)

Initial payment reserves the child's space in the program and is paid in advance of the child's start date. The initial payment will equal 10% of the monthly payment. Initial 10% deposits are **non-refundable.**

Patrons Printed Name: _____ Date: _____

Patrons Signature: _____

Child(ren) Names in CDC/FCC:_____

Parent Central Services Staff Initials: _____

CHILD & YOUTH SERVICES USDA LETTER

Effective 1 July 2021

Dear Parent/Guardian:

Children need healthy meals to learn. Child & Youth Services offers healthy meals every day. Although all children receive meals at no charge, the U.S. Department of Agriculture (USDA) provides funds that support the nutrition program based on your child's eligibility. This letter is a request for you to complete the information on the enclosed application to assist our agency's food service program.

1. **DO I NEED TO FILL OUT AN APPLICATION FOR EACH CHILD?** No. Use one Meal Benefit Application for all children in your household. We cannot approve an application that is not complete, so be sure to fill out all required information. Return the completed application to: CYS Parent Central Services, 1900 Reece Road, Fort Meade, MD 20755.

2. **ADDITIONAL USDA REIMBURSEMENT IS AVAILABLE TO OUR AGENCY FOR MEALS SERVED TO CHILDREN IN THE FOLLOWING HOUSEHOLDS:**
   - getting money or help from the Food Supplement Program (FSP) or Temporary Cash Assistance (TCA).
   - with Foster children.
   - with a gross income within the free limits or reduced limits on the Federal Income Eligibility Guidelines.
   - with children certified as homeless, runaway, Head Start, Early Head Start, Even Start or migrant.
   - with some people participating in WIC.

3. **I COMPLETED AN APPLICATION LAST YEAR. DO I NEED TO FILL OUT A NEW ONE?** Yes. Your child's application is only good for one year. You must send in a new application each year.

4. **WILL THE INFORMATION I GIVE BE CHECKED**? Yes and we may also ask you to send written proof.

5. **MAY I APPLY 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.

6. **WHO SHOULD I INCLUDE AS MEMBERS OF MY HOUSEHOLD?** You must include all people living in your household, related or not (such as grandparents, other relatives, foster children, or friends) who share income and expenses. You must include yourself and all children living with you. If you live with other people who are economically independent (for example, people who you do not support, who do not share income with you or your children, and who pay a pro-rated share of expenses), do not include them.

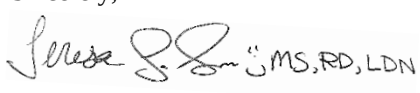
7. **WHAT IF MY INCOME IS NOT ALWAYS THE SAME?** List the amount that you normally receive. For example, if you normally make $1000 each month, but you missed some work last month and only made $900, put down that you made $1000 per month. If you normally get overtime, include it, but do not include it if you only work overtime sometimes. If you have lost a job or had your hours or wages reduced, use your current income.

8. **WE ARE IN THE MILITARY. DO WE REPORT OUR INCOME DIFFERENTLY?** Your basic pay and cash bonuses must be reported as income. If you get any cash value allowances for off-base housing, food, or clothing, it must also be included as income. However, if your housing is part of the Military Housing Privatization Initiative, do not include your housing allowance as income. Any additional combat pay resulting from deployment is also excluded from income.

9. **MY FAMILY NEEDS MORE HELP. ARE THERE OTHER PROGRAMS WE MIGHT APPLY FOR?** To find out how to apply for **FSP, TCA, and medical assistance programs** or other assistance benefits, contact your local assistance office or call 1-800-332-6347.

If you have other questions or need help, call (301) 677-1149/1156

Sincerely,



Teresa L. Turner, MS, RD, LDN, SNS, FAND
CYS Nutritionist

INSTRUCTIONS FOR COMPLETING MEAL BENEFIT APPLICATION – Child Care Center

Complete the application using the instructions below. Sign the form and return it to the center. If you need help, call **(301) 677-1149/1156**.

STEP 1 – CHILDREN'S INFORMATION - ALL HOUSEHOLDS COMPLETE

List the first and last name of all enrolled children. Indicate if a foster child, homeless, migrant, runaway, or in Head Start, Early Head Start or Even Start by checking the box. If **ALL** children listed are foster, homeless, migrant, runaway, or in Head Start, Early Head Start, or Even Start, skip to Step 4.

STEP 2 – CASE NUMBER

If **any** member of your household receives benefits from the Food Supplement Program (FSP) or Temporary Cash Assistance (TCA), write the case number and skip to Step 4.

STEP 3 – NAMES OF ALL HOUSEHOLD MEMBERS AND GROSS INCOME

- List the first and last name of everyone in your household, whether they receive income or not. Your household includes all those living as one economic unit. Include yourself, all children living with you, including foster children and any other person living in your household, related or not. List each type of income received last month and how often it is received. You must indicate how much in whole dollars, and how often received (weekly, bi-weekly, twice a month, monthly, yearly). **If a household member has no income—write '0' in the income box**.
- Report all income as gross income. Gross income is the amount earned before taxes and other deductions. This is not the same as take- home pay. Gross income includes unemployment benefits, Worker's Compensation, Supplemental Security Income and Veteran's benefits, Social Security, private pensions or disability, strike benefits, income from trusts or estates, annuities, investment income earned interest, rental income and regular cash payments from outside household. For self-owned business, farm, or rental income, report income as **net income**.
- If you are in the Military Housing Privatization Initiative, do not include your housing allowance as income. Do not include combat pay.
- Indicate the total number of household members in the space provided.
- The form must have the last four digits of the Social Security Number of the primary wage earner or adult who signs unless the adult does not have a Social Security Number. If the adult does not have a Social Security Number, check the box. The last four digits of the Social Security Number are not needed if you listed a FSP or TCA case number, or if you are only applying for foster children.

STEP 4 – SIGNATURE - ALL HOUSEHOLDS COMPLETE

All forms must have the signature of an adult household member.

STEP 5 – RACIAL/ETHNIC IDENTITY

You are not required to answer this question to get meal benefits. This information will help ensure that everyone is treated fairly.

Federal Income Eligibility Guidelines

Household Size	Year	Month	Week
1	$23,828	$1,986	$ 459
2	32,227	2,686	620
3	40,626	3,386	782
4	49,025	4,086	943
5	57,424	4,786	1,105
6	65,823	5,486	1,266
7	74,222	6,186	1,428
8	82,621	6,886	1,589
For each additional family member add:	$ 8,399	$ 700	$ 162

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced-price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number are not required when you are only applying for foster children, or you list a Food Supplement Program or Temporary Cash Assistance case number, 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 lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

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:

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

fax: (202) 690-7442; or

email: program.intake@usda.gov.

This institution is an equal opportunity provider.

The Maryland State Department of Education does not discriminate on the basis of age, ancestry/national origin, color, disability, gender identity/expression, marital status, race, religion, sex, or sexual orientation matters affecting employment or in providing access to programs and activities and provides equal access to the Boy Scouts and other designated youth groups. For inquiries related to Department policy, please contact: Agency Equity Officer, Equity Assurance and Compliance Office, Office of the Deputy State Superintendent for Finance and Administration, Maryland State Department of Education, 200 W. Baltimore Street - 6th Floor, Baltimore, Maryland 21201-2595, 410-767-0426 – voice, 410-767-0431 – fax, 410-333-6442 - TTY/TDD.

INCOME ELIGIBILITY GUIDELINES
(Effective July 1, 2021 through June 30, 2022)

Household Size	Free Meals					Reduced-Price Meals				
	Yearly	Monthly	Twice per month	Every Two Weeks	Weekly	Yearly	Monthly	Twice per month	Every Two Weeks	Weekly
1	$16,744	$1,396	$698	$644	$322	$23,828	$1,986	$993	$917	$459
2	22,646	1,888	944	871	436	32,227	2,686	1,343	1,240	620
3	28,548	2,379	1,190	1,098	549	40,626	3,386	1,693	1,563	782
4	34,450	2,871	1,436	1,325	663	49,025	4,086	2,043	1,886	943
5	40,352	3,363	1,682	1,552	776	57,424	4,786	2,393	2,209	1,105
6	46,254	3,855	1,928	1,779	890	65,823	5,486	2,743	2,532	1,266
7	52,156	4,347	2,174	2,006	1,003	74,222	6,186	3,093	2,855	1,428
8	58,058	4,839	2,420	2,233	1,117	82,621	6,886	3,443	3,178	1,589
For each additional family member add . . .	$5,902	$492	$246	$227	$114	$8,399	$700	$350	$324	$162

Use the following procedures for evaluating household income on free and reduced-price meal applications when comparing to the Income Eligibility Guidelines (IEGs):

- If a household has only one income source, or if all sources are the same frequency, do not use conversion factors. Compare the income, or the sum of incomes, to the published IEG for the appropriate frequency and household size to make the eligibility determination.

- If a household reports income sources at more than one frequency, annualize all income by multiplying weekly income by 52, income received every two weeks by 26, income received twice a month by 24, and income received monthly by 12. Do NOT round the values resulting from each conversion. Sum all the unrounded converted values and compare the unrounded total to the IEGs for annual income for the appropriate household size.

Meal Benefit Application for Child Care Centers

July 1, 2021 - June 30, 2022

For more information, read **Instructions for Completing** or call (301) 677-1149/1156

Step 1 — List all enrolled children (if more spaces are required for additional names, attach another sheet of paper).

Children in **Foster Care** and children who meet the definition of **Homeless, Migrant, Runaway, Head Start, Early Head Start or Even Start** are eligible for free meals. If **ALL** children listed are foster, homeless, migrant, runaway or in Head Start, Early Head Start or Even Start, skip to Step 4.

First and Last Names of All ENROLLED	Check all that apply:					
	Foster Child	Homeless	Migrant	Runaway	Head Start Early Head Start	Even Start

Step 2 — Do any Household Members (including you) currently participate in the Food Supplement Program (FSP) or Temporary Cash Assistance (TCA)?

Pick one Yes

If you answered **NO**, complete Step 3.
If you answered **YES**, provide a case number then go to Step 4

Case Number: | | | | | | | | | |

Step 3 — Report Income for ALL Household Members (skip this step if you answered 'Yes' to Step 2)

List all Household Members (including yourself) even if they do not receive income. For each Household Member listed, if they receive income, report total gross income (before taxes) for each source in whole dollars only. If they do not receive income from any source, enter '0'. If you enter '0' or leave any fields blank you are certifying (promising) that there is no income to report.

How Often = Weekly, Every 2 Weeks, Monthly, Twice a Month or Yearly

First and Last Names of ALL Household Members	Earnings from Work		Child Support, Alimony, Public Assistance		Pensions, Retirement, Other Income	
	Income	How Often?	Income	How Often?	Income	How Often?

Total Household Members (Children and Adults): | |

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member: | | | |

Check if No SSN: ☐

Step 4 — Contact Information and Adult Signature

I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that officials may verify (check) the information. I am aware that if I purposely give false information, I may be prosecuted under applicable State and Federal laws. I understand my child's eligibility status may be shared as allowed by law.

Printed Name:		Signature:	
Street Address:			
Date:		Phone #:	

Step 5 — OPTIONAL: Children's Racial and Ethnic Identities

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community.

Ethnicity (Check One):

☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race (Check one or more):

☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

DO NOT FILL OUT THIS SECTION. CENTER USE ONLY

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

Total Income (Children and Adults): $ _____

☐ Weekly ☐ Every 2 Weeks ☑ Twice a Month ☐ Monthly ☐ Yearly

Eligibility: ☐ Free ☐ Categorically Eligible ☑ Reduced ☐ Paid

Determining Official's Signature: _____ Date: _____

Date Withdrawn: _____

Maryland State Department of Education
Office of School and Community Nutrition Programs

CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
ENROLLMENT FORM

Instructions for Completion:

- All parent/guardians are to complete this form for each child enrolled at the child care center/home participating in CACFP.
- List the child's name, birth date, the days and hours normally in care and the meals received while in care.
- CACFP Federal regulations require that an enrollment form be **completed annually** and signed by the child's parent or guardian.

Name of Child Care Center/Home

1. Child's Name		**Child's Date of Birth (MM/DD/YYYY)**
Times Child Normally in Care (For example 7:30 AM – 5 PM) **Hours from:** _____ **to** _____	**Check (✓) the days your child normally attends:** ☐ Monday ☐ Thursday ☐ Tuesday ☐ Friday ☐ Wednesday ☐ Saturday ☐ Sunday	**Check (✓) the meals that your child will receive while in care:** ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

2. Child's Name		**Child's Date of Birth (MM/DD/YYYY)**
Times Child Normally in Care (For example 7:30 AM – 5 PM) **Hours from:** _____ **to** _____	**Check (✓) the days your child normally attends:** ☐ Monday ☐ Thursday ☐ Tuesday ☐ Friday ☐ Wednesday ☐ Saturday ☐ Sunday	**Check (✓) the meals that your child will receive while in care:** ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

3. Child's Name		**Child's Date of Birth (MM/DD/YYYY)**
Times Child Normally in Care (For example 7:30 AM – 5 PM) **Hours from:** _____ **to** _____	**Check (✓) the days your child normally attends:** ☐ Monday ☐ Thursday ☐ Tuesday ☐ Friday ☐ Wednesday ☐ Saturday ☐ Sunday	**Check (✓) the meals that your child will receive while in care:** ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

Parent/Guardian Signature _____ Date Signed _____

Parent/Guardian's Name: _____ Phone: _____

ARMY CHILD AND YOUTH SERVICES HEALTH SCREENING TOOL

For use of this form, see AR 608-75; the proponent agency is OACSIM.

PRIVACY ACT STATEMENT

AUTHORITY:	10 U.S.C. 3013, Secretary of the Army; 29 U.S.C. 794, Nondiscrimination Under Federal Grants and Programs; DoDD 1342.17 Family Policy; AR 608-75, Exceptional Family Member Program; AR 608-10, Child Development Services.
PRINCIPAL PURPOSE:	Information will be used to assist Army activities in their responsibilities in overall execution of the Army's Exceptional Family Member Program (EFMP) and the Army Child and Youth Services Program.
ROUTINE USES:	The DoD "Blanket Routine Uses" that appear at the beginning of the Army's compilation of systems of records apply to this system.
DISCLOSURE:	Disclosure of requested information is voluntary; however, if information is not provided individual may not be able to participate in Army Child and Youth Services Program.

Part A - General Information

1. Child's Name	2. Date of birth (YYYYMMDD)
3. Family member prefix	
4. Type of placement requested	5. Date (YYYYMMDD)
6. Sponsor name	
7. Spouse name	

8. Home phone	9. Duty phone	10. Cell phone

Part B - Identification of Child/Youth Condition/Restrictions

Child has any of the following conditions/restrictions: (Check yes or no)

1. Allergies
   ☐ No ☐ Yes (explain)

   a. Life threatening reaction
   ☐ No ☐ Yes (explain)

   b. Epi-pen required
   ☐ No ☐ Yes

   c. Other allergic reations (hives, rash, diarrhea)
   ☐ No ☐ Yes

2. Asthma reactive airway disease
   ☐ No ☐ Yes (explain)

   a. Triggers exist for child's asthma attacks (stress, environmental, exercise)
   ☐ No ☐ Yes (explain)

   b. Child routinely (greater than 10 days per month/four months per year) uses inhaled anti-inflammatory agents and/or bronchodilators
   ☐ No ☐ Yes (explain)

   c. Child has taken steroids during the past year (prednisone, prednisolone)
   ☐ No ☐ Yes (indicate number of days in past year)

d. Child has experienced unconsciousness or seizures associated with asthma attacks
☐ No ☐ Yes (explain)

e. Child required an urgent visit to emergency room or clinic for acute asthma within the last 12 months
☐ No ☐ Yes (indicate number of visits in the past year)

f. Child has been hospitalized for asthma related condition in the past six months
☐ No ☐ Yes (explain)

3. Attention Deficit Disorder (ADD)
☐ No ☐ Yes

a. ADD with hyperactivity
☐ No ☐ Yes

b. Is not well controlled with medication
☐ No ☐ Yes (not well controlled)

c. Behavioral/conduct concerns
☐ No ☐ Yes (explain)

4. Autism
☐ No ☐ Yes

5. Behavioral/conduct concerns (for example, oppositional defiant disorder, anxiety disorder, school phobias)
☐ No ☐ Yes (explain)

6. Blindness/visual problems
☐ No ☐ Yes (explain)

7. Diabetes
☐ No ☐ Yes (explain)

8. Emotional problems that require care by a psychiatrist, psychologist or social worker
☐ No ☐ Yes (explain)

9. Epilepsy
☐ No ☐ Yes (explain)

10. Hearing problems
☐ No ☐ Yes (explain)

11. Heart problems
☐ No ☐ Yes (explain)

12. Kidney problems
☐ No ☐ Yes (explain)

13. Speech/language delay
☐ No ☐ Yes (explain)

14. Physical disability
☐ No ☐ Yes (explain)

15. Dietary restrictions
☐ No ☐ Yes (explain)

16. Assistance with activities of daily living

☐ No ☐ Yes (explain)

17. Other conditions

☐ No ☐ Yes (specify and explain)

Part C - Medications

Child is on medications on a regular basis

☐ No ☐ Yes (If yes, please list medications and indicate which require administration during child care hours.)

Part D - Early Intervention and Special Education

Child has an Individualized Family Service Plan (IFSP), Individualized Education Plan (IEP) or 504 plan

☐ No ☐ Yes

Part E - Exceptional Family Member Program (EFMP) Enrollment

Child is enrolled in the EFMP

☐ No ☐ Yes (specify for what condition)

I authorize _____ (name of Medical Treatment Facility or physician's practice) to release any medical information regarding my child _____ (name of child) to the _____ (name of installation) Child Youth Services (CYS)/Special Needs Accommodation Process (SNAP) personnel and their staff that is necessary to conduct SNAP review. This authorization will remain in effect for one year. I understand I may revoke this consent in writing at any time before expiration, but any action taken by the CYS/SNAP in reliance on this authorization prior to revocation is valid and will remain in effect.

I understand that information disclosed pursuant to this authorization is For Official Use Only (FOUO) and may be subject to redisclosure. I understand that information redisclosed is no longer protected by DoD 6025.18-R; however, confidentiality of this information will remain protected by the Privacy Act of 1974, 5 U.S.C. section 552a.

The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.

_____ _____

Signature of Parent or Personal Representative of Child Date (YYYYMMDD)