YWCA School Age Child Care Program
Registration Checklist- SDOL

Child's name:______________________ Site: YWCA of Lancaster

Child's School:__________________

______Application Form
______Center Agreement
______Consent/Release Form
______Getting to Know Your Child Form
______Emergency Contact Form – MUST BE COMPLETE
______Health Appraisal Form
______CACFP Form (Food Program)
______Calendar Received _____BSP _____FT _____PT

_____ASP _____FT _____PT

____________Membership expires (include form for new/renew memberships)

Payment Information: _____Funded Caseworker__________________

_____Self Pay Verified By___________________

Checked By__________________

-For Office Use Only-

$__________Membership ($15 if not current) $ __________ $50 deposit/copay

$__________Registration ($10 per family – fee waived if currently in our program)

$_________**Total**

Receipt Number:

Initials: ____________________ Date: ____________________

(*Membership fees, Registration fee and deposit are non-refundable)

Start Date_____________________ Site Notified_____________________

YWCA School Age Child Care Program
Application Form

Child's Name:______________________________ Birth Date:____________________

Gender (circle one): Male Female Ethnicity (White, Black, etc.) _________

School child attends: ______________ Child's Teacher: __________________

Grade (2010-2011 school year): _________________

Marital Status of Parents: _____ Married _____ Single _____ Divorced

Are there any custody issues we should be aware of? _____Yes _____No

____

	Parent 1	**Parent 2**
Name	_________________	_________________
Home Address	_________________	_________________
	_________________	_________________
Home Telephone	_________________	_________________
Cell Phone	_________________	_________________
Date of Birth	_________________	_________________
Social Security #	_________________	_________________
Employer	_________________	_________________
Occupation	_________________	_________________
Business Address	_________________	_________________
	_________________	_________________
Business Phone	________________	_________________
E-mail Address	_________________	_________________

YWCA SCHOOL AGE CHILD CARE PROGRAM
CENTER AGREEMENT
55 PA CODE CHAPTERS 3270.123 &.181(c);3290.123 &.181(c)

Name of Child: ______________________________ Site: YWCA of Lancaster

Fee Amount: $__________________________ Per: ______Day ______ Week

Early/ Late Fee: $1 per minute after 6:00pm and before 6:30am

Day payment due: Every Friday

Termination Policy: Two weeks written notice.
Services to be provided: YWCA Programs as outlined in the Parent Handbook
Developmentally Appropriate Activities
Afternoon Snack

Child's Arrival Time Before School: ______ Child's Departure Time After School: _______

Civil Rights Compliance Parent Awareness

In accordance with applicable Federal and State civil rights laws and regulatory requirements, you and your children, as clients of the YWCA have the right to be provided services by YWCA and to be referred for services at other facilities without regard to your race, color, religious creed, disability, ancestry, national origin, age or sex. If you feel you have been discriminated against, complaints of discrimination may be filed with any of the following:

YWCA of Lancaster Attn: Maureen Powers 110 N. Lime St. Lancaster, PA 17602

Department of Public Welfare
Bureau of Equal Opportunity
P.O. Box 2675
Harrisburg, PA 17105

US Dept. of Health & Human Services
Office of Civil Rights
Suite 372 Public Ledger Bldg.
150 S. Independence Mall West
Philadelphia, PA 19106

PA Human Relations Comm.
Riverfront Office Center
1101 S. Front St. 5th Fl.
Harrisburg, PA 17104

Payment responsibility: Please list person(s) who will be responsible for payments: ______________________________

I, parent/guardian;

_____ Received complete written program information/parent handbook at the time of enrollment (3270.121, 3280.121,3290.121) I agree to abide by all policies and procedures stated.

_____ Agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at minimum. (3270.124, 3280.124, 3290.124)

Staff Signature Date ______________________ Parent/Guardian Signature Date ______________________

Date of Child's Admission	Periodic Review
Date of Withdrawal	Signature of Parent or Guardian Date

YWCA SACC Program: Parental Consent/Release Form

Child's Name ______________________________

I grant permission for my child to:

	YES	NO	
			I. Permission to participate in Center activities:
1.	____	____	Use Center play equipment & materials while under supervision of staff.
2.	____	____	Participate in all Center activities.
3.	____	____	Leave premises for walks/field trips, while under the supervision of staff.
4.	____	____	Be included in pictures, & recordings connected with the program.
5.	____	____	Swim in the YWCA pool & other pools.
6.	____	____	Ride in the YWCA van & busses for field trips.
7.	____	____	Allow YWCA staff to apply sunscreen throughout the day.
8.	____	____	**II. Permission for emergency medical treatment:** I authorize the treatment of my child, ____________, by a qualified and licensed physician in the event of a medical emergency, which in the opinion of the attending physician, may endanger the child's life, cause disfigurement, physical impairment, or undue discomfort if delayed. I grant permission for Center Staff to administer first aid and to take whatever action necessary to obtain or administer emergency care.
9.	____	____	**Emergency Procedure:** An ambulance is called (911) if the need is indicated. Please indicate your choice of hospital: ______________. The parent is notified immediately thereafter. If parent cannot be reached, contact person is called. If both parent and contact person cannot be reached, the child's physician is called. Center staff accompanies child to hospital and remains until authorized person arrives.
10.	____	____	**III. Permission for administration of prescription medication.**
11.	____	____	**IV. I understand that if my child damages any items at the SACC Program, the price of these items will be added to my weekly bill.**

12. **Individualized Education Plan (IEP) & Individualized Family Service Plans (IFSP) Information Sheet:** Please indicated with a check mark one of the following:

____ I am providing a copy of my child's IEP/IFSP
____ I am not providing a copy of my child's IEP/IFSP
____ This is not applicable to my child

Parent's Signature__________________________________ Date __________

Childs Name: ____________________________ **Date:** ______________

Getting to Know Your Child

Please take time to answer a few questions about your child and your family. This will help our child care staff better care for your child.

1. **What kinds of things do you and your child like to do together?**

2. **Are there any custody issues that our staff need to be aware of?**

3. **Who is included in your household? Please include names and relation to the child.**

4. **Is this your child's first childcare experience? If so, how often has your child been away from you or his primary care giver?**

5. **Does your child strongly dislike any foods?**

6. **Does you child have any strong fears?**

7. **If there are any other issues/concerns that our staff should be aware of please write them below.**

EMERGENCY CONTACT / PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124(a)(b), 3270.181 & .182, 3280 124 (a)(b), 3280.181 & .182: 3290.124 (a)(b). 33290.181 & .182

CHILD'S NAME	BIRTHDATE
ADDRESS	
MOTHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
ADDRESS	Cell#:
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	
FATHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
ADDRESS	Cell #:
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	

EMERGENCY CONTACT PERSON(S)	NAME	TELEPHONE NUMBER WHEN CHILD IS IN CARE

PERSON(S) TO WHOM CHILD MAY BE RELEASED	NAME	ADDRESS	TELEPHONE NUMBER WHEN CHILD IS IN CARE

NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER	TELEPHONE NUMBER
ADDRESS	
SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTION)
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICATION, SPECIAL CONDITIONS
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD	
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS	POLICY NUMBER (REQUIRED)

PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT

OBTAINING EMERGENCY MEDICAL CARE	ADMIN. OF MINOR FIRST - AID PROCEUDURES
WALKS AND TRIPS	SWIMMING
TRANSPORTATION BY THE FACILITY	WADING

PERIODIC REVIEW

SIGNATURE OF PARENT or GUARDIAN ______________________ DATE ____________

SIGNATURE OF PARENT or GUARDIAN ______________________ DATE ____________

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST) (FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH: HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:	
FACILITY PHONE: COUNTY:	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

Parents may write immunization dates; health professional should verify and complete all data.

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)
☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Child and Adult Care Food Program
Child Enrollment Form

Enrollment Date:

Child ______________________
Address ______________________
____
Birth date ______________

Parent/Guardian ______________________
Address ______________________
____
Telephone (home)__________(work)__________

Sponsoring Organization YWCA of Lancaster
Address 110 N. Lime St.
Lanc. PA 17602

Center/Home CEC/SACC
Address 110 N. Lime St.
Lanc. PA 17602

Normal Hours of Care (write in times)*

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Start: End:	Start: End:	Start: End:	Start: End:	Start: End:	Start: N/A End:	Start: N/A End:

* If more than 8 hours of care per day, please attach an explanation to this form.

Daily Expected Meal Service Participation (please check box)

Breakfast	AM Snack	Lunch	PM Snack	Supper	Eve Snack
	N/A			N/A	N/A

Is this child of school age? ___Yes ___No If yes, will additional meals be provided when school is not in session? ___Yes ___No If yes, please specify the meal: ___Breakfast ___Lunch ___Snack

Parental Contacts: This child care facility participates in the Child and Adult Care Food Program. In order to receive federal funds, representatives of the sponsoring organization or the State Agency may contact you to verify your child's participation. Please indicate what time and method of contact you prefer:

_____Day _____Evening _____Time

_____Letter _____Telephone (home) _____Telephone (work)

Signature ______________________ **Date** ______________
Parent/Guardian

Signature ______________________ **Date** ______________
Center Administrator/Home Provider

"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. (Not all prohibited bases apply to all programs)."

" To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer."

For Sponsor Use Only

Child withdrew on ______________________

CACFP SAMPLE LETTER TO HOUSEHOLDS – NON-PRICING INSTITUTIONS

Dear Parent/Guardian:

Please complete, sign and return the attached Meal Benefit Application to YWCA Child Enrichment Center as soon as possible. All children enrolled in our center receive their meals at no charge; however, we must determine family income to receive federal funds for the meals served to children. All meals must meet nutrition standards established by the U.S. Department of Agriculture (USDA). If a child has been determined by a recognized medical authority to be unable to consume certain foods because of medical or other special dietary needs, the center will make any substitution as prescribed by that medical authority. Substitutions will be made when supported by a statement from the recognized medical authority. If a substitution is required, there will be no extra charge for the meal. Please contact us for further information at (717) 393-1735.

For All Households: You must complete the attached Meal Benefit Application and return it to the center.
USDA defines a household as a group of related or unrelated individuals (not residents of a boarding house or an institution) who are living as one economic unit (i.e.; sharing living expenses). Therefore, the income reported on the Meal Benefit Application must include the gross income of all members of your household by source. The income you report must be the total gross income listed by source for each household member 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 your household's income is equal to or less than the amounts indicated for your household's size on the Reduced Price Meal Income Chart, the center receives a higher level of reimbursement for meals served to your child(ren).

Households receiving Food Stamps or TANF only have to include your child(ren)'s name(s) and the nine digit Food Stamp or TANF case number, and an adult signature for the application to be complete. The nine digit case number is the number sent to you by the County Assistance Office. You cannot use the numbers on your Medical Assistance or EBT Access Cards.

Households that do not receive Food Stamps or TANF must include the names of all household members, the amount of income each member received last month and where the income came from. An adult household member must sign the application and include their social security number, or indicate that they do not have a social security number.

Households with a foster child must include the foster child's name and the amount of "personal use" income the child received last month. An adult must sign the application.

Reduced Price Meal Income Chart
(July 1, 2009 – June 30, 2010)

Household Size	Annual	Monthly	Weekly
1	20,036	1,670	386
2	26,955	2,247	519
3	33,874	2,823	652
4	40,793	3,400	785
5	47,712	3,976	918
6	54,631	4,553	1,051
7	61,550	5,130	1,184
8	68,469	5,706	1,317
For each additional member add	+6,919	+577	+134

Must I Report Changes? You should notify us if you become unemployed and the loss of income during the period of unemployment causes your household income to be within eligibility standards.

Will Information On My Application Be Kept Confidential? We will use the information on the form to decide the level of reimbursement our center is eligible to receive. We may inform officials of other child nutrition, health and education programs of the information on this form to determine benefits for those programs.

Can I Apply For Free Or Reduced Price Meals Later? You may apply for free or reduced price meals at any time during the year. If you are not eligible now but have a decrease in household income, an increase in household size, become unemployed or begin to receive Food Stamps or TANF, complete a Meal Benefit Application at that time.

Program Non-Discrimination Clause: "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. (Not all prohibited bases apply to all programs). To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer."

Sincerely,

Cheryl L. Gahring – Director of Childcare Services

SINGLE/MULTI-CHILD MEAL BENEFIT APPLICATION FOR FREE AND REDUCED PRICE MEALS

To apply for free or reduced price meals, complete one Meal Benefit Application for the child(ren) in your household that attend day care, sign your name and return the Meal Benefit Application to the day care center/home sponsor. If you have any questions, please contact the day care center or home sponsor at **717-393-1735**.

1. Print Each Child's Name and School Information:

Full Name	Age	Day Care Center/Day Care Home

2. Food Stamp or TANF Cash Assistance Number:

3 6 - ___ ___ ___ ___ ___ ___ ___

Enter the nine (9) Digit Case Number assigned by the County Assistance Office. If you entered a nine digit Case Number, **SKIP TO PART 5.**

3. Foster Child: Yes ___ No ___ List the child's monthly personal use income. Write "0" if the child has no personal use income. $__________ **SKIP TO PART 5**

4. Household Members and Income: List all adults and children in household. Provide source, amount and how often you receive income or indicate no income. Income to report includes earnings from work, pensions, retirement, social security, welfare, child support, savings, alimony and other income. See Instructions for examples of other income.

NAMES OF ALL HOUSEHOLD MEMBERS:	SOURCE OF INCOME		AMOUNT RECEIVED				
	Source 1	Source 2	WEEKLY	EVERY 2 WEEKS	TWICE A MONTH	MONTHLY	YEARLY
			$	$	$	$	$
			$	$	$	$	$
			$	$	$	$	$
			$	$	$	$	$
			$	$	$	$	$

Total Number of Household Members: __________

5. SIGNATURE AND SOCIAL SECURITY NUMBER: I certify the information listed above is current and correct and all income was reported. I understand this information is being given for the receipt of Federal funds; school officials may verify the information on this Meal Benefit Application; and deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

X______________________________ X______________________

Signature of Adult Household Member **Social Security Number ***

Print Name of Signer ______________________ Home Telephone No. ______________ Work Telephone No. ______________

Street/Apt. No. ______________________ City/State/Zip ______________ Date ______________

*Privacy Act Statement: Section 9 of the National School Lunch Act requires that, unless your child(ren)'s food stamp or TANF Case Number is provided, you must include the Social Security Number of the Adult Household Member signing the Meal Benefit Application or indicate that the household member does not have a Social Security Number. ***Provision of a Social Security Number is not mandatory, but if a Social Security Number is not given or an indication is not made that the signer does not have such a number, the Meal Benefit Application cannot be approved.*** The Social Security Number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the Meal Benefit Application. These verification efforts may be carried out through program reviews, audits and investigations and may include contacting employers to determine income, contacting a food stamp or welfare office to determine current certification for receipt of Food Stamp or TANF benefits, contacting the State Employment Security Office to determine the amount of benefits received and checking the documentation produced by household members to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims or legal actions if incorrect information is reported. The social security number may also be disclosed to programs as authorized under the National School Lunch Act and the Child Nutrition Act, the Comptroller General of the United States, and law enforcement officials for the purpose of investigating violations of certain Federal, State and local education, health and nutrition programs.

6. RACIAL/ETHNIC IDENTITY: Please mark one or more racial identities. You are not required to complete this information.

____ American Indian/Alaskan Native ____ Asian ____ Black/African American ____ Native Hawaiian/Pacific Islander ____ White

Please check one of the following ethnic identities: ______ Hispanic or Latino ______ Not Hispanic or Latino

The U.S. Department of Agriculture (USDA) prohibits discrimination in all its programs and activities on the basis of race, color, national origin, sex, disability or age. Persons with disabilities who require alternative means for communication of program information (Braille, large print, audiotape, etc.) should contact USDA's TARGET Center at (202) 720-2600 (voice and TDD).
To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 14th and Independence Avenue, SW, Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

FOR CENTER/HOME SPONSOR USE ONLY
Monthly Income Conversion: Weekly X 4.33; Every 2 Weeks X 2.15; Twice a Month X 2

Categorically eligible for free benefits by Food Stamps _____ or TANF _____
Or
Total Household Size _________ Monthly Income _____________
Eligibility Determination: Approved Free ______ Reduced Price _______ Paid _______

Temporary Until _________ Until ___________ Until ____________ Until ____________

Date Withdrawn ____________________

Signature of Determining Official ____
Date __________________

FOR CENTER PRICING PROGRAMS ONLY

Date Verification Notice Sent __________ Response Due From Household __________Second Notice Sent __________
Verification Result: No change _____ Free to Reduced _____ Free to Paid _____ Reduced to Free _____ Reduced to Paid _____
Reason for Change: Income __________ Household Size __________ Refused to Cooperate __________
Change in Food Stamp/TANF __________ Other ______________________________

Date Notice of Change Sent __________ Verifying Official's Signature ______________________________
Date __________

FOR HOME SPONSOR USE ONLY
Tier 1 Home Determination

Provider's Previous Year's Income _______________ (Attach IRS 1040 and Schedule C) or Food Stamp ________ (Attach Food Stamp Verification)

Eligibility Determination: Tier 1 Eligible _____ Tier 1 Not Eligible _____ Tier 2 Mixed _____

Signature of Determining Official: ____
Date: __________________