# SACC BEFORE/AFTER SCHOOL FAQ'S

## THANK YOU FOR YOUR INTEREST IN OUR PROGRAM!

During the School year all programming takes place in the best possible environment for each respective participant at our participating school locations. Programming is built around the interests, needs and comfort of each individual child. To the extent it is possible to do so; children with special needs are integrated into all programs made available to their peers. Our programs are designed to challenge and inspire.

### WHO DO I CONTACT FOR...?

- Billing/Payment Questions & Contract Changes: Jill Keck, Childcare Finance Assistant, jkeck@dubuquey.org; 563.556.3371
- Child Absence from Program: School site cell phone (see below)
- Program Questions & Schedules: Jen Knutson, School Age Coordinator, jknutson@dubuquey.org; 563.556.3371
- Teresa Fischer, Childcare Director, tfischer@dubuquey.org; 563-556-3371

### WHAT IS THE CELL PHONE NUMBER FOR MY CHILD'S SCHOOL SITE?

- Bryant: 563.258.2481
- Carver: 563.258.2512
- Eisenhower: 563.258.2580
- Epworth: 563.599.4175
- Hoover: 563.451.2380
- Irving: 563.258.2486
- Kennedy: 563.258.2478
- Sageville: 563.258.2473
- Seton: 563.258.0881
- Table Mound: 563.258.2545

### HOW I CHANGE THE DAYS MY CHILD ATTENDS THE PROGRAM?

All schedules/schedule changes are due in writing by Tuesday the week prior to the change to Jen Knutson at jknutson@dubuquey.org. If you need to make a contract change you must fill out the childcare change form 2 weeks prior to the change to Jill Keck at jkeck@dubuquey.org.

### HOW DOES PART-TIME WORK?

If you choose our part-time option your child/ren may attend up to 3 days per week. For Part-Time Before and After school this means three full days. You may not split them up, for example, your child may not attend Monday before and Tuesday after school and that count as one of their days.

### WHAT ARE THE PROGRAM HOURS FOR BEFORE AND AFTER SCHOOL CARE?

- Before care: 6:30 AM-start of school
- After care: school dismissal-6:00 PM
- Late Starts: 6:30 AM-start of school
- Early Outs: school dismissal-6:00 PM
- Non-School Days(care is at the Dubuque Community YMCA/YWCA): 6:30 AM-6:00 PM

### HOW DO I SIGN UP FOR NON-SCHOOL DAYS?

Non-School Day Request Contracts are required in order to have your child attend on days outside of before & after school care. You can find these forms online at www.dubuquey.org. Please turn these contracts in to Jill Keck at jkeck@dubuquey.org or in person at the Dubuque Community YMCA/YWCA 10 days prior to the non-school day. We cannot guarantee a spot will be available on the day of care. Non-school day fees are included for all children that are registered for the full time Before & After School option. All other registered children will have a fee to attend on any non-school days. All tuition, late fees, and DHS copays fees, must be paid before your child can attend a non-school day. On early out nonscheduled days, your child can attend directly after school to designated YCare area until 6:00 PM. If your child is not currently enrolled in an after school YCare program, fees will apply and your account on file will be charged.

Continued on next page

**WHAT IF MY CHILD PARTICIPATES IN A PROGRAM IN THE SCHOOL OUTSIDE OF BEFORE AND AFTER SCHOOL CARE?**
If your child participates in a program in the school outside of before and after school care, we will need a Transfer/Permission to Release form for each program. This form will allow us to safely and knowingly transfer children from Before & After Y care to another program. These forms will be provided at the y-care school locations.

**DO I NEED TO SIGN MY CHILD(REN) IN/OUT DURING THE MORNING/EVENING SESSIONS?**
**Yes –** It is MANDATORY that parents sign time in/out and signature during both sessions. Children must be brought into designated YCare area. If students are dropped off outside of building you will be terminated.

**WHO IS AUTHORIZED TO PICK UP MY CHILD?**
Upon registration, you will have to fill out a MANDATORY form listing the individuals who are authorized to pick up your child. At dismissal, the individual will have to show their identification and sign the "sign-out sheet." Your child will not be released to any persons under the age of 16 or anyone not listed on the authorized pick-up form. If for any reason someone other than those on your list will be picking up your child, you need to call the Dubuque Community YMCA/YWCA to let us know of any change. If there is a court order preventing a parent from picking up a child, a copy must be provided to the Child Care Coordinator.

**WHAT IF I'M LATE PICKING-UP MY CHILD FROM A SACC SCHOOL SITE?**
An extra fee of $1 per minute will be charged if your child is in attendance after our program hours. Note: Any child who has not been picked up by 6:00 p.m. without notice to the Y from a parent or guardian will be turned over to the proper authorities, which includes notification of both police and the Department of Human Services. The appropriate fees will be drafted from your account on file.

**CAN MY CHILD BRING GAMES OR TOYS FROM HOME?**
**NO** - the children are not allowed to bring toys, games or electronics to SACC. The Dubuque Community YMCA/YWCA is NOT responsible for lost or broken items. Please NO cell phones.

**CAN MY CHILD BRING FOOD IN FROM HOME?**
**NO -** We aren't able to have children bring food from home due to children with severe food allergies.

**IS THE SACC PROGRAM A LICENSED PROGRAM?**
**Yes-** All Dubuque YMCA/YWCA Before/After School programs are licensed with Department of Human Resources, and all of our staff are highly trained to ensure a safe and productive environment.

**WHAT ARE THE RESPONSIBILITIES OF THE SITE SUPERVISORS AND THE CHILDREN?**
It is the responsibility of the Site Supervisors to make the atmosphere safe and fun for your child. It is their job to keep the children interacting in a positive manner. All children are responsible for following the rules to maintain a safe and enjoyable atmosphere for everyone. This includes acting responsibly and respectfully at all times. From time to time, the need arises for a warning letter to be sent to parents regarding their child's behavior. It is at the discretion of the Site Supervisor as to when an incident report is to be filed with the Child Care Director. It is then at the discretion of the Director as to whether a disciplinary letter is sufficient, or if a meeting to establish an action plan, needs to be set up with the parents. It is also at the discretion of the Director as to whether a child is to be dismissed from the program. For further information, please refer to the discipline policy.

**FINANCIAL ASSISTANCE**
Families that receive DHS assistance must pay their parent copay fees either on bi-weekly or monthly auto payment.

# 2017-2018 BEFORE & AFTER SCHOOL PROGRAMS FEE CONTRACT

**Child's Name:**________________________________________ Birth Date:__________ Sex:__________
Last First MI

Address:______________________________ City:______________ State:_______ Zip Code:__________

Start Date:_______________ School:_________________________ Grade Level in Fall:______________

**Primary Payer:**____________________________________ **Relationship to Student**:______________

SS #:____________________ Address:_____________________________________ Zip Code:__________

Birthdate:_________________ Cell Phone:____________________ Work Phone:____________________

Employer:____________________________________ E-mail:______________________________________

**Secondary Payer:**__________________________________ **Relationship to Student**:______________

SS #:____________________ Address:_____________________________________ Zip Code:__________

Birthdate:_________________ Cell Phone:______________________ Work Phone:____________________

Employer:____________________________________ E-mail:______________________________________

**Weekly Enrollment Status** (check the box that applies to your child) All rates are billed monthly.

| | **Full Time (4-5 Days)** | **Part Time (1-3 Days)** |
|---|---|---|
| **Before School Only** | ☐ $150 | ☐ $100 |
| **After School Only** | ☐ $220 | ☐ $140 |
| **Before and After School** | ☐ $260 | ☐ $200 |
| ***Friday Before Only** | ☐ $52 Monthly | |

**Additional Information:**

- 10% Discount for Dubuque Community YMCA/YWCA Members
- 10% Discount per additional child
- **All fees are paid two weeks in advance of service**
- **Registration Fee: $50.00 per family per program**
- One vacation week to use per family - (five consecutive days)
- All Schedule changes including vacation must be submitted in writing to the Finance Department two weeks in advance. Submit to jkeck@dubuquey.org
- * If you select Friday Before Only option you are responsible for all Fridays that month

**Agency Assistance** (attach documentation, such as current approval letter)

☐ None ☐ Promise Jobs ☐ CCR&R ☐ Y Scholarship ☐ Other: ____________________

☐ DHS *Please note that, by selecting this option, you acknowledge that you are responsible for any co-pays. If your DHS Child Care Assistance application is denied or if your approval lapses, you are responsible for any fees that may be incurred. Therefore, you must complete a payment method below.

**Membership Status:**

☐ Y Member ☐ Non-Member

**Payment Method: (choose one)**

☐ **Credit/Debit Card (Auto draft in advance)**
I authorize the Dubuque Community YMCA/YWCA (DCY) to charge my child care expenses directly to my MasterCard or Visa. This authority will remain in effect until I notify the DCY in writing no less than two weeks in advance to cancel this agreement. Please print clearly.

Credit Card #: ______________________________ Exp. Date: ____________ CVV#: _____

☐ **ACH Authorization (Auto draft in advance)**
I authorize the Dubuque Community YMCA/YWCA (DCY) and the Bank named below to initiate variable debit/credit entries to my checking/savings account. This authority will remain in effect until I notify the DCY in writing to cancel this agreement. Please attach a voided check or deposit ticket.

Bank Name: ______________________ Routing/Transit #: ___________________________

Acct #: _________________________ ☐ Checking ☐ Saving

I understand that payment for service is due no less than two weeks in advance. I understand that service may be suspended if I fail to keep my account current without making satisfactory payment arrangements. In addition, I understand it is my responsibility to provide **written notice at least two weeks in advance** to stop service. If you stop service and withdraw from the program, you will be responsible for paying an additional registration fee to return to care. I understand that I will be charged for the schedule for which I have registered and that no refunds will be given unless the change in schedule is pre-approved by the Child Care Finance Assistant.

**Parent/Guardian Signature:**____________________________ **Date:**______________

I have been informed of the current Dubuque Community YMCA/YWCA Child Care Handbook and where it is available at my child's site.

**Parent/Guardian Signature:**____________________________ **Date:**______________

**For office use only:**

| | | |
|---|---|---|
| ☐ Fee Contract | ☐ Additional Child Discount | ☐ Signature |
| ☐ Emergency Contact Form | ☐ Membership Discount | ☐ Payment Method Completed |
| ☐ Child Health Form | ☐ Registration/ 1st months Fees | ☐ DOB & SSN Completed |
| ☐ Child Immunization Form | ☐ Date Received | |

Staff Initials: ________

**DUBUQUE COMMUNITY YMCA/YWCA**
**Cool School Child Care Program**
**Phone: 563-556-3371 Fax: 563-556-2728**
**Email schedules to: jknutson@dubuquey.org**

## CHILD SCHEDULE FORM

Parent's Name: ______________________________________________

Child's Name: ______________________________________ Age: __________

2nd Child's Name: ___________________________________ Age: __________

3rd Child's Name: ___________________________________ Age: __________

4th Child's Name: ___________________________________ Age: __________

**Schedules are due in the Y Child Care Office by TUESDAY for the coming week**.
They may be faxed, emailed, or brought to the Y.

**Is this a permanent schedule?** ☐ **Yes** ☐ **No**

- If your child attends the morning program until school begins, please fill in your estimated arrival time. (Example: 7:00-SCH ((SCH=School))
- If your child attends the afternoon program right after school dismisses, please fill in estimated pick-up time. (Example: DIS-5:30 ((DIS=Dismissal))

**Week of:** ______________________________

My child will attend…

| | AM | PM |
|---|---|---|
| M | ______-______ | ______-______ |
| T | ______-______ | ______-______ |
| W | ______-______ | ______-______ |
| Th | ______-______ | ______-______ |
| F | ______-______ | ______-______ |

**Week of:** ______________________________

My child will attend…

| | AM | PM |
|---|---|---|
| M | ______-______ | ______-______ |
| T | ______-______ | ______-______ |
| W | ______-______ | ______-______ |
| Th | ______-______ | ______-______ |
| F | ______-______ | ______-______ |

**Week of:** ______________________________

My child will attend…

| | AM | PM |
|---|---|---|
| M | ______-______ | ______-______ |
| T | ______-______ | ______-______ |
| W | ______-______ | ______-______ |
| Th | ______-______ | ______-______ |
| F | ______-______ | ______-______ |

**Week of:** ______________________________

My child will attend…

| | AM | PM |
|---|---|---|
| M | ______-______ | ______-______ |
| T | ______-______ | ______-______ |
| W | ______-______ | ______-______ |
| Th | ______-______ | ______-______ |
| F | ______-______ | ______-______ |

# PARENTAL EMERGENCY MEDICAL CONSENT

**This form must be presented upon admission for treatment**

This form allows parents and guardians to authorize the provision of emergency treatment for below named child who becomes ill or injured while under program authority when parents or guardians cannot be reached.

In the event reasonable attempts to contact have been unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by the doctor or dentist listed below, or if unavailable, another licensed physician or dentist.

I agree to pay all costs and fees as secured or authorized under this consent.

| **CHILD'S NAME:** | | **BIRTH DATE:** |
|---|---|---|
| **PARENT(S)/GUARDIAN(S) WITH WHOM THE CHILD RESIDES** | | |
| **1. NAME** | RELATIONSHIP TO CHILD | |
| ADDRESS | EMPLOYER | |
| HOME NUMBER | CELL NUMBER | WORK NUMBER |
| **2. NAME** | RELATIONSHIP TO CHILD | |
| ADDRESS | EMPLOYER | |
| HOME NUMBER | CELL NUMBER | WORK NUMBER |
| **EMERGENCY CONTACT PERSON(S)** | | |
| **1. NAME** | RELATIONSHIP TO CHILD | |
| HOME NUMBER | CELL NUMBER | WORK NUMBER |
| **2. NAME** | RELATIONSHIP TO CHILD | |
| HOME NUMBER | CELL NUMBER | WORK NUMBER |
| **3. NAME** | RELATIONSHIP TO CHILD | |
| HOME NUMBER | CELL NUMBER | WORK NUMBER |

| **PERSONS AUTHORIZED TO PICK UP CHILD** | **ADDRESS** | **PHONE NUMBER** |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |

***Are there any custody or restraining orders for person(s) who may attempt to pick up or have contact with the child while in care at the center?***

| **Name** | **Name** |
|---|---|

| **PHYSICIAN NAME** | **DENTIST NAME** |
|---|---|
| PHONE NUMBER | PHONE NUMBER |
| ADDRESS | ADDRESS |
| HOSPITAL PREFERENCE | |
| KNOWN ALLERGIES | DATE OF LAST TETANUS |
| PRESENT MEDICATION | |
| INSURANCE COMPANY | POLICY HOLDER ID |

**This consent will be in effect for one year beginning (date)** ______________________

______________________________
**SIGNATURE OF PARENT OR GUARDIAN** **DATE**

______________________________
**SIGNATURE OF PARENT OR GUARDIAN** **DATE**

# SCHOOL-AGE ASSESSMENT & HEALTH FORM & IMMUNIZATION DECLARATION

**1. HEALTH STATEMENT** - To be completed by parent.

______________________________________________________________

Child's Full Name                                        Birth Date

1. Significant illnesses and surgeries child has had (give age at time):

______________________________________________________________

______________________________________________________________

2. Any special health-related needs of child (allergies, medications, injuries, etc.):

______________________________________________________________

______________________________________________________________

**2. PHYSICAL ASSESSMENT**

1. Is there any defect of vision, hearing or speech of which the child care program should be aware, or could compensate by appropriate action?

______________________________________________________________

______________________________________________________________

2. Is this child subject to any conditions which limit classroom activities or physical education?

______________________________________________________________

______________________________________________________________

3. Is this child subject to any condition which may result in an emergency situation?

______________________________________________________________

______________________________________________________________

4. Is this child subject to any mental or physical condition for which he/she should remain under periodic medical observation?

______________________________________________________________

______________________________________________________________

5. Other information you would like to share:

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

FOR CENTERS SERVING SCHOOL-AGE CHILDREN OPERATING IN THE SAME SCHOOL FACILITY IN WHICH THE CHILD ATTENDS SCHOOL:

**My signature below certifies that immunization information concerning my child has been provided and is available in the school file.**

Parent's Signature______________________________Date ______________________________

# Iowa CACFP Child Care Center Parent/Guardian Letter - Non-pricing (front) 7/2016

**Purpose: The attached Iowa Eligibility Application is used to determine eligibility for free and reduced price meal reimbursement. The instructions for completion are on the back of this letter.**

Dear Parent or Guardian:

This center participates in the Child and Adult Care Food Program (CACFP) administered by the United States Department of Agriculture (USDA). Participants are not charged separately for meals. However, by participating in this Program, the center receives partial reimbursement for nutritious meals served to children. The amount of reimbursement the center receives is determined by the information you provide. Providing information can help your center purchase nutritious food. Higher reimbursement will be given to the center for meals served to enrolled children from families whose income is at or below the level shown in the chart below. Please read the instructions on the back, complete, sign and return the attached income application as soon as possible. An application that does not contain all required information cannot be used by the center. If required information is missing, free or reduced-price meal benefits will be denied. Call your center if you need help with the form. The information reported on this form will be filed and treated as confidential.

A foster child who is the legal responsibility of a welfare agency or court may be certified as eligible for free meals regardless of your household income. See instructions on the back for more information.

If you do not qualify now to receive free or reduced price meals, you may apply for benefits at any time during the year. If you have a decrease in household income, have an increase in family size, or have enrolled children that become eligible for food assistance or FIP, you may fill out an application at that time.

**Income Eligibility Guidelines for Reduced Price Meals**
**Effective 7-1-2016 to 6-30-2017**

| Household Size | Reduced Price Meals | | | | |
|---|---|---|---|---|---|
| | Yearly | Monthly | Twice per Month | Every Two Weeks | Weekly |
| 1 | $21,978 | $1,832 | $916 | $846 | $423 |
| 2 | $29,637 | $2,470 | $1,235 | $1,140 | $570 |
| 3 | $37,296 | $3,108 | $1,554 | $1,435 | $718 |
| 4 | $44,955 | $3,747 | $1,874 | $1,730 | $865 |
| 5 | $52,614 | $4,385 | $2,193 | $2,024 | $1,012 |
| 6 | $60,273 | $5,023 | $2,512 | $2,319 | $1,160 |
| 7 | $67,951 | $5,663 | $2,832 | $2,614 | $1,307 |
| 8 | $75,647 | $6,304 | $3,152 | $2,910 | $1,455 |
| For each additional family member add: | + $7,696 | + $642 | + $321 | + $296 | + $148 |

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

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. The last four digits of the social security number of the adult household member who signs the application must be listed. The social security information is not required when you apply on behalf of a foster child or if you list a Food Assistance number, or Family Investment Program 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 CACFP. 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.

**USDA 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.

# Instructions for Completing Iowa Eligibility Application

**Complete both sides of an application for each household.**

**All applicants should complete Part 1.** This application may be used to apply for benefits in school meals or milk programs, child care centers and home based care for children. Check all boxes that apply to your family. You may make copies of a completed application for each program in which your child participates.

**FIP OR FOOD ASSISTANCE HOUSEHOLD MEMBER, including child(ren) in Head Start or Even Start**, follow these instructions.

**Part 3.** List one FIP or Food Assistance **Case Number** per household in the area provided. **Use the Case Number listed in the DHS Notice of Decision**. Eligibility based on Head Start or Even Start is available only if your child is enrolled in Head Start and documentation from the Head Start agency is provided. **NOTE: Medicaid, Title XIX and EBT card numbers are not acceptable.**

**Part 4.** List the name, date of birth, grade (if applicable), name of school/Head Start/child care center attended for each child in your household. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of your child's ethnic and racial status if you do not complete this section.

**Part 5.** Skip this section.

**Part 6.** Read the certification and complete this section.

**HOMELESS, MIGRANT OR RUNAWAY, follow these instructions.**

**Part 2.** For children attending school, check if any child is Homeless, Migrant, or a Runaway and call your child's school.

**Part 4.** List the name, date of birth, grade (if applicable), name of school/Head Start/child care center attended for each child in your household. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of your child's ethnic and racial status if you do not complete this section.

**Part 5.** Skip this section.

**Part 6.** Read the certification and complete this section.

**FOSTER CHILD IN HOUSEHOLD**, follow these instructions. A foster child is a child who is living with a household but who remains the legal responsibility of the welfare agency or court. Foster children can be included as household members or included on a separate application.

**Part 4**. List the child's name, date of birth, grade (if applicable), name of school/Head Start/child care center attended. Check the box for foster child. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of your foster child's ethnic and racial status if you do not fill this section.

**Part 5.** Complete this section only if the foster child receives money for personal use or has other regular personal income. If the foster child has no income, check the box indicating no income. DO NOT include the stipend received by the foster family to provide care to the foster child.

**Part 6.** Read the certification and complete this section.

**ALL OTHER HOUSEHOLDS,** including WIC households, follow these instructions for reporting income.

**Part 4**. List the name, date of birth, grade (if applicable), name of school/Head Start/child care center/home attended for each child in your household. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of each child's ethnic and racial status if you do not complete this section.

**Part 5.** Follow these instructions to report total household income from last month.

- **Name:** List the last and first names of **each** person living in your household, related or not (such as grandparents, other relatives, or friends); include yourself and all children living with you. The household decides whether to include the foster child on their household application with non-foster children. Attach another sheet of paper if needed.
- **Age:** List the age of each household member.
- **Check if No Income:** Put a mark in the box if the household member **does not** have an income.
- **Gross Income last month and how it was received:** Report the amount of income received in the appropriate Gross Income column (weekly, every 2 weeks, twice monthly, **or** monthly). 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. If you have a household member for whom last month's income was higher or lower than usual, list that person's expected average income. If the household includes the foster child, they must report any personal income received by the foster child on the foster parent's household application.
- **Other Monthly Payments or Income:** Money is reported in this section if it is regularly received. List the amount each person received last month from welfare, child support, alimony, adoption subsidies, pensions, retirement, Social Security, Supplemental Security Income (SSI), and Veteran's benefits (VA benefits). In the **All Other Income** column, include Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, cash withdrawn from savings, investments or trusts, interest and **ANY OTHER INCOME**. Use the Self-Employment Income Worksheet on the back of the application to calculate net income for self-owned businesses, farm, or rental income and report in the **All Other Income** column. **Do not report**: Scholarships, educational benefits, lump sum payments, combat pay, Deployment Extension Incentive Pay (DEIP) or children's incidental income from occasional activities such as babysitting, shoveling snow, or cutting grass. If you are in the Military Housing Privatization Initiative or get combat pay do not include these allowances.
- **Social Security Number:** If the application is being made on the basis of income, the adult signing the form must provide the last 4 digits of his or her Social Security number or mark the "I do not have a Social Security number" box. If you do not provide your Social Security information or mark the box, your application cannot be processed.

**Part 6.** Read the certification and complete this section.

# Iowa Eligibility Application

FFY 16-17

**Complete one application per household. School Year 2016-2017**

**Part 1. Check all applicable boxes:**
- ☐ school meals
- ☐ special milk (restrictions apply)
- ☐ children in child care center
- ☐ Tier I home provider (HP)
- ☐ Head Start/Even Start
- ☐ children in child care home(HP) Provider name:

**Part 2. Check if any child is Homeless, Migrant, or a Runaway and call your child's school.** ☐ Run away ☐ Migrant ☐ Homeless

**Part 3. FIP or Food Assistance Eligible**: Enter the FIP or Food Assistance Case Number for ANY household member as listed in the Notice of Decision. NOTE: Medicaid, Title XIX and EBT card numbers are not acceptable. Skip part 5.

**Name of household member with Case Number ______________________________ List Case Number ____________________________**

**Part 4. Children enrolled. REQUIRED OF ALL APPLICANTS.**

List name(s) of all enrolled child(ren) in your household.

| Last Name | First Name | Middle Name or Initial | Check box for FOSTER child | Date of Birth | Grade | OPTIONAL | | Name of School/Head Start/ Child Care Center/Home |
|---|---|---|---|---|---|---|---|---|
| | | | | | | ETHNICITY | RACE | |
| 1. | | | ☐ | | | | | |
| 2. | | | ☐ | | | | | |
| 3. | | | ☐ | | | | | |
| 4. | | | ☐ | | | | | |
| 5. | | | ☐ | | | | | |

**Part 5. Total Household Gross Income. DO NOT COMPLETE PART 5 IF YOU LISTED A FIP OR FOOD ASSISTANCE NUMBER IN PART 3. Report the gross income received by EACH household member one time in the correct column: weekly, every 2 weeks, twice a month or monthly. Gross income is the amount earned before taxes and other deductions, not take-home pay. Report all other monthly income received. Self-employed persons, see the worksheet on reverse side of this application.**

| List the names of everyone living in your household, including the children listed in Part 4. Attach a separate page if more space is needed. For FOSTER children, include only money available for child's personal use or child's own income. | | | | **Gross Income: Report income by how often the household member is paid.** | | | | Other Monthly Payments or Income Received. | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Last Name | First Name | Age | Check if NO Income | Gross amount earned weekly | Gross amount earned every 2 weeks | Gross amount earned twice a month | Gross amount earned monthly | Welfare, child support, alimony, adoption subsidies | Pension, retirement, social security, SSI, VA benefits | All other income |
| 1. | | | ☐ | | | | | | | |
| 2. | | | ☐ | | | | | | | |
| 3. | | | ☐ | | | | | | | |
| 4. | | | ☐ | | | | | | | |
| 5. | | | ☐ | | | | | | | |

Last four digits of my Social Security Number: **X XX - X X -** ___ ___ ___ ___ ☐ I do **not** have a Social Security Number.
If Part 5 is completed, the adult signing the form must provide the last 4 digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. **For further information refer to the Privacy Act Statement in the parent letter.**

**Part 6. Certification and Signature. REQUIRED OF ALL APPLICANTS.**
I certify (promise) that all information on this application is true and that all income is reported if required. I understand that I will receive benefits from Federal funds based on the information I give. I understand that officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal/milk benefits, and I may be prosecuted. Email of Adult Completing Form____________________________________________

Signature of Adult Completing Form ____________ Printed Name of Adult Completing Form ____________ Date Signed ____________

Address of Adult Completing Form ____________ Town ____________ ZIP Code ____________ Work Phone ____________ Home Phone ____________ Cell Phone ____________

**Part 7. DO NOT WRITE BELOW THIS LINE. FOR ADMINISTRATIVE USE ONLY.**
Income conversion factors for annual income: weekly X 52; two weeks X 26; twice a month X 24; monthly X 12
Household Income: $ ___________ ☐ Weekly ☐ Every 2 Weeks ☐ Twice Monthly ☐ Monthly ☐ Annually Household Size _______

Application Approved: ☐ Income ☐ Foster Child (free) ☐ FIP/Food Assistance ☐ Head Start DOCUMENTATION REQUIRED ☐ Homeless/Migrant/Runaway (Schools only)

Eligibility Determination: ☐ Free Meals ☐ Reduced Price Meals ☐ Free Milk
Application Denied: ☐ Incomplete ☐ Over income limits

CACFP HP ONLY:
☐ Tier 1 Area (Provider's own children)
☐ Tier 1 Income (All children)
☐ Tier 1 Child (Tier 2 mixed)

**Determining Official Signature** ____________________ **Effective Date** ____________

## *hawk-i* /Medicaid Information Form: Read this information and sign if you do not want your name released to *hawk-i* or Medicaid.

If your children do not have health insurance, many families getting free and reduced price meals can also get free or low-cost health insurance for their children.

The law requires schools to share your free and reduced price meal eligibility information with Medicaid and *hawk-i*, the State's medical insurance program for children. Specifically, we will give them your child's name and your name and address. Medicaid and *hawk-i* can only use the information to identify children who may be eligible for free or low-cost health insurance and then to contact you. They are not allowed to use the information from your free and reduced meal application for any other purpose.

Childcare organizations may share this information at their option.

You are not required to allow us to share information from your children's free and reduced price meal application with Medicaid or the *hawk-i* program. It will not affect your children's eligibility for free and reduced price meals. If you do NOT want your information shared with Medicaid or *hawk-i*, you must tell us by completing the information below at the time you complete this eligibility application. If you want further information, you may call *hawk-i* at 1-800-257-8563.

**I DO NOT want school/home sponsor/child care or Head Start center officials to share information from my free and reduced price meal application with Medicaid or *hawk-i*. Also, if you are already receiving Medicaid or *hawk-i*, please sign below. This will avoid another contact.**

Child's Name: ____________________________________ School/Child Care/Head Start Center:_____________________

Child's Name: ____________________________________ School/Child Care/Head Start Center:_____________________

Child's Name: ____________________________________ School/Child Care/Head Start Center:_____________________

**Parent/Guardian Name (Printed)**_________________________________ **Signature**_______________________________________ **Date**_________

## Self-Employment Income Worksheet: This worksheet will assist you in calculating the amount to report if you engage in farming, are self employed, or have income from other sources.

Persons who are engaged in farming or who operate other types of private businesses may experience variations in cash flow or monthly income throughout the year. These persons may use their income tax records from the preceding calendar year as a basis for applying for the free and reduced price meals. The income to be reported is income derived from the business venture less operating costs incurred in the generation of that income. Deductions for personal expenses such as medical expenses and other non-business deductions are not allowed in reducing gross business income.

If you have additional income from other kinds of employment, this income must be treated as separate and apart from the income generated from your business venture. USDA **DOES NOT** recognize income the same way as IRS. USDA does not permit a loss from a business venture to off-set earnings from wages or salary. Though your business may have suffered a net operational loss, for purposes of this application, it is not possible to have a negative income. **The least self employed income possible is zero (no income).** For example, if you operated a business at a net loss but held another job where you received wages, your income for purposes of applying for free or reduced price meals would be the income from your wages only. The loss from the business cannot be deducted from the amount of the income earned in the other job.

A prior year loss from farming or other private business operation cannot be used to reduce the current year net income for determining free and reduced price eligibility. Wages paid to a spouse or other family member in the operation of a farm or private business must be shown as household income in Part 5 of the application.

**Income from private business operations is to be taken from your most recent U.S. Individual Income Tax Return - Form 1040. Use the lines from the 1040 that are identified.**

| | |
|---|---|
| Line 12 - Business income or (loss) | $ ______________________ |
| Line 13 - Capital gain or (loss) | $ ______________________ |
| Line 14 - Other gains or (losses) | $ ______________________ |
| Line 17 - Rental real estate, royalties, partnerships, S corporations, trusts, etc. | $ ______________________ |
| Line 18 - Farm income or (loss) | $ ______________________ |
| Total | $ ______________________ |
| **The least income possible is zero (a negative number cannot be reported)** | Total ÷12* = ______________________ |

*Enter amount in the "All Other Income Last Month" column in Part 5 on the front of the Iowa Eligibility Application.

**Optional Waiver Information (for Schools only)**

Your child is enrolled in a center that participates in the Child and Adult Care Food Program (CACFP). By participating in this Program, the center follows Federal meal pattern requirements and receives reimbursement to assist with food costs. The CACFP requires that parents provide specific enrollment information on an annual basis. This form will be placed in center files and treated as confidential information.

Revised 6/2016

## Iowa Child and Adult Care Food Program
## Child Care Enrollment Form

| | | Times of Care | | Regular Days of Care | | | | | | | Meals Served During Care | | | | | | Ethnicity/Race* | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Last Name, First Name | Birthdate | Arrival | Departure | M | T | W | Th | F | S | S | B | AM Sn | Lu | PM Sn | D | E Sn | Ethnicity | Race |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |

*Ethnicity (Select one and enter in the chart above): H=Hispanic or Latino or N=Not Hispanic or Latino
Race (Select one or more and enter in the chart above): W=White, B=Black or African American, I=American Indian or Alaska Native, A=Asian, and P=Pacific Islander
This information is requested by the Federal Government in order to monitor compliance with civil rights law. You are not required to furnish this information, but are encouraged to do so. The law requires that a program recipient may neither discriminate on the basis of this information nor on whether you choose to furnish it. However, if you choose not to furnish it, this Program representative is required to note race/ethnicity on the basis of visual observation or surname.

**Infants only (0 to 12 months):** ☐ I am not enrolling an infant (skip this section)

As a participant in a USDA Child Nutrition Program, our center offers meals to children of all ages. Infant feeding is based on current nutrition guidelines. Infant foods are appropriate for the age and developmental readiness of your infant. Please select (X ) your choice(s) of the following options that will fulfill your infant's food needs.

☐ I will provide breastmilk for my infant. Center formula may be used to supplement feedings if necessary: ☐Yes ☐No

☐ I will provide infant formula for my infant. Name of formula: ____________________

☐ I accept the center's formula for my infant. Name of formula: ________________________

☐ I will provide a statement from a prescribing medical authority for non-reimbursable formula. Name of formula: ____________________________________

☐ I accept the center's solid foods (appropriately textured) to be served to my infant as s/he is ready for them, and after I have discussed it with the caregiver.

☐ I will provide solid foods for my infant*. The center may supplement with additional solid foods when my infant needs them: ☐Yes ☐No

*The parent may provide no more than one reimbursable food item in order for the center to claim the meal. DHS licensed centers must follow CACFP infant meal pattern requirements regardless of who supplies the food. Your center can provide a copy of the CACFP infant meal pattern and a list of reimbursable foods upon request.

Parent Signature_______________________________________ Date:___________

Parent Signature_______________________________________ Date:___________ (Make any needed changes above, sign and date)

Parent Signature_______________________________________ Date:___________ (Make any needed changes above, sign and date)

*USDA is an equal opportunity provider and employer.*

# 2017-2018 SCHOOL-AGE PROGRAM RATES

## BEFORE & AFTER SCHOOL PROGRAMS

| | First Child | Add. Child |
|---|---|---|
| | Monthly | Monthly |
| **Full Time (4 or 5 Days)** | | |
| Before School Only | $150 | $135 |
| After School Only | $220 | $198 |
| Before & After School | $260 | $234 |
| **Part Time (1, 2 or 3 Days)** | | |
| Before School Only | $100 | $90 |
| After School Only | $140 | $126 |
| Before & After School | $200 | $180 |
| **Friday Late Start** | | |
| Friday AM Only | $52 | $46.80 |
| **Non-School Days (School Year, Snow Days)** | | |
| Pre-registered | $30 daily | $27 daily |
| Late registration | $45 daily | $40.50 daily |

## COOL SCHOOL SUMMER PROGRAM

| | First Child | Each Additional |
|---|---|---|
| | Weekly | Weekly |
| **Full Time (4 or 5 Days)** | | |
| Registering for all weeks | $150 | $135 |
| Registering for select weeks | $165 | $148.50 |
| **Part Time (1, 2 or 3 Days)** | | |
| Registering for all weeks | $100 | $90 |
| Registering for select weeks | $110 | $100 |

## ADDITIONAL INFORMATION

- 10% DISCOUNT FOR MEMBERS
- REGISTRATION FEE: $50 PER FAMILY PER PROGRAM
- ALL FEES MUST BE PAID TWO WEEKS IN ADVANCE
- REGISTRATION IS NOT COMPLETE UNTIL A COMPLETED ENROLLMENT PACKET, REGISTRATION FEE AND FIRST TWO WEEKS FEES ARE SUBMITTED