FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

BEST SUMMER EVER!

FRIENDSHIP. ACCOMPLISHMENT. BELONGING.

Summer Day Camp Enrollment Packet
KENOSHA YMCA

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Spending the Summer with Friends!!!

Dear Parents,

Scheduling is **ONLINE** at kenoshaymca.org! In this packet are the enrollment forms needed prior to first day of camp.

If you already have a YMCA account you can log in and enroll your child(ren) online in their designated age group..

* If you do not have a YMCA account please go to our website at kenoshaymca.org and choose "Create an Account" and you will be redirected to create a family account for the first time. Once you have an account for you and your child(ren), you can enroll online in their designated age group under Y Kids 2022 Summer Camp. Our Full Day Camp is $40 per day.

We offer half day camp for $20 per day. You have an option to choose the Morning Half Day with drop off as early as 6:30 am and pick by 12:00 pm, or our Afternoon Half Day with drop off after 12:30 pm and pickup by 6:00 pm. If your child will be attending summer school then please choose the afternoon half day on those scheduled summer school days.

Your child(ren) will officially be enrolled when **ALL** forms and **online registration** are complete and turned in to the Kenosha YMCA. The Enrollment Fee of $25.00 per child is due at time of registration. **No child may attend a session without it being paid in full.** Payments and schedules are due 7 days prior to your child's attendance.

You will automatically have a payment plan set up at the time of registration. The credit card/bank account you use at checkout will be charged on each of the payment due dates.

If you have any questions, please do not hesitate to contact our Youth and Family Office at 262.654.9622 ext. 207. We look forward to building relationships with your kids and helping to meet the needs of your family.

Please start planning to attend our **Summer Day Camp Orientation, Saturday, June 4th, 10:00-12:00.** Everyone will have the opportunity to meet the staff, ask questions, and experience some of the SDC games and activities being planned.

Dr. M. Rachel Mall
Youth and Family Director
rmall@kenoshaymca.org
262.654.9622 ext. 238

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
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March 1, 2022

Dear Summer Camp Families,

The Kenosha YMCA is committed to the safety of all our participants in our Youth and Family Programs.

Starting June 13th, we will require for you and all your authorized family and friends to receive a Youth and Family Pick Up Pass in order to enter our YMCA to pick up your child(ren) from our care.

All authorized family and friends you list on your enrollment forms will be entered under your child's name in our system. The Membership Desk Staff will know who is authorized to receive a Pick Up Pass.

Please stop by our Membership Desk to receive your pass. Once you have your pass you can use it through the last day of Summer Camp. If you enroll your child(ren) for future Youth and Family Programs such as our Before and After Care Enrichment Program, we will adjust the expiration date for you and make any adjustments you request.

Sincerely,

Youth and Family Office
youthandfmaily@kenoshaymca.org
262-654-9622 ext. 207

FOR YOUTH DEVELOPMENT®
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Welcome to another Best Summer Ever!!

In an effort to better serve our parents and campers this summer, we have revamped our Parent pick-up/Aftercare location and procedures. We open camp at **6:30am** and end camp at **6:00pm** daily. For Morning Half Day Camp arrival can be as early as **6:30am** and pick no later than **12:00pm**. For Afternoon Half Day Camp drop off no earlier than **12:30pm** and pickup by **6:00 pm.**

Any parent that arrives after 9:00 am or before 4:00 pm needs to contact their child's camp group via Brightwheel.

Groups are designated by the age your child is at time of enrollment.

Camp Director: Keeliah Hampton
262.654.9622 ext. 207
khampton@kenoshaymca.org or via Brightwheel.

Lead Staff per Age Group:

Campers Ages 5-6 yrs: Evelyn Serrano-Boney at esboney@kenoshaymca.org

Campers Ages 7-8yrs: Rhys O'Keefe at rokeefe@kenoshaymca.org

Campers Ages 9-10 yrs: Julian Wilkerson at jwilkerson@kenoshaymca.org

Campers Ages 11-12 yrs: Gabby Gideon at ggideon@kenoshaymca.org

**** Staff is subject to change due to illness, ratio of groups and other foreseen circumstances****

Sumer Camp Flag will be visible at sign in/out table.

Drop off before 9:00AM and Pick up after 4:00 PM

Kenosha YMCA Summer Camp 2022

7101 53rd St. Kenosha, Wi. 53144 - 262-654-9622 - kenoshaymca.org

Please fill out in Blue or Black Ink ONLY!

Child's Full Name	Gender (circle) Select	First Day of Attendance / /	Last Day of Attendance / /
Address (City, State & Zip code required)	**Telephone #**	**DOB**	**Age**

Age Group: (based on age at time of enrollment, CIRCLE one)

4K, 4-5 yr olds | 5-6 yr olds | 7-8 yr olds | 9-10 yr olds | 11-12 yr olds

T-Shirt Size (circle)

Youth S | Youth M | Youth L | Adult S | Adult M | Adult L

Parent or Guardian (provide the information requested for EACH parent or guardian.)

****NOTE: All parents/guardians will be permitted to visit during center hours unless access is prohibited or restricted by a court order****

Legal Guardian #1 First and Last Name	Address (City, State & Zip code required)	Home # / Cell #
Work Name & Address	Work #	Email Address
Legal Guardian #2 First and Last Name	Address (City, State & Zip code required)	Home # / Cell #
Work Name & Address	Work #	Email Address

Child lives with : Both Parents | Mother | Father | Grandparent(s) | Guardian

Special Custody Concerns: → This Section MUST be signed even if there are NO concerns ←

Are there any custody concerns regarding this child that we need to be aware of while the child is in our care?

Please Attach any documentation (court order, etc.) to back up all custody concerns.

Yes | No If YES, please explain: _____

X Signature of Parent or Guardian Date

Physician & Medical Facility Information

Physician Name	Address	Phone #

Preferred Medical Facility - Please Circle one or select other:

Aurora Medical - 100400 75th St. | **Kenosha Hospital - 6308 8th Ave.** | **St. Catherine's - 9916 75th St.** | **Other** _____

I hereby give my consent for emergency medical care or treatment, to be used ONLY if I cannot be immediately reached.

X Signature of Parent or Guardian Date

AUTHORIZED PEOPLE TO CALL & EMERGENCY CONTACT FOR YOUR CHILD. (Provide additional names & information for people authorized to: Contact when parent/guardian cannot be reached who can receive information on your child and are authorized as a pick-up person that staff can release your child into his/her care)

Contact #1 First and Last Name	Home #	Cell #
Address (City, State & Zip code required)	Relationship to child	
Contact #2 First and Last Name	Home #	Cell #
Address (City, State & Zip code required)	Relationship to child	

I have had an opportunity to review the policies of the day care center and a summary of the Wisconsin Rules for Licensed Day Care Centers. YES | NO

I will be receiving state assistance (Wisconsin Shares) towards summer camp fees . YES | NO

I give permission for my child to participate in Field Trips and other activities during operating hours. Walking YES | NO **Transported*** YES | NO

*Transported Field Trips always require an additional permission slip. This slip will include all details of the field trip.

X **Signature of Parent or Guardian** **Date Signed**

HEALTH HISTORY AND EMERGENCY CARE PLAN

Use of form: This form is required for family and group child care centers and day camps to comply with DCF 250.04(6)(a)1., DCF 251.04(6)(a)6., and DCF 252.41(4)(a)6. of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

CHILD INFORMATION

Name (Last, First, MI)	Birthdate (mm/dd/yyyy)	First Day of Attendance (mm/dd/yyyy)

Home Address (Street, City, State, Zip Code)

PARENT / GUARDIAN INFORMATION Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

Name	Primary Telephone Number	Work Telephone Number	Secondary Telephone Number
Name	Primary Telephone Number	Work Telephone Number	Secondary Telephone Number

PHYSICIAN / MEDICAL FACILITY INFORMATION

Physician Name	Medical Facility Address	Telephone Number

SUNSCREEN / INSECT REPELLENT AUTHORIZATION If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 250.07(6)(h)6., Authorizations shall be reviewed periodically and updated as necessary. Per DCF 251.07(6)(g)3., authorizations shall be reviewed every 6 months and updated as necessary.

☐ Yes ☐ No I authorize the center to apply sunscreen to my child. ☐ Yes ☐ No I authorize the center to allow my child to self-apply sunscreen.	Brand Name	Ingredient Strength
☐ Yes ☐ No I authorize the center to apply repellent to my child. ☐ Yes ☐ No I authorize the center to allow my child to self-apply repellent.	Brand Name	Ingredient Strength

HEALTH HISTORY AND EMERGENCY CARE PLAN If available, attach any health care plan information from the child's physician, therapist, etc.

1. Check any special medical condition that your child may have.

☐ No specific medical condition

☐ Asthma ☐ Diabetes ☐ Gastrointestinal or feeding concerns, including special diet and supplements

☐ Cerebral palsy / motor disorder ☐ Epilepsy / seizure disorder ☐ Any disorder, including Cognitively Disabled, LD, ADD, ADHD, or Autism

☐ Other condition(s) requiring special care – Specify.

☐ Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.

☐ Food allergies – Specify food(s).

☐ Non-food allergies – Specify.

2. Triggers that may cause problems – Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication – Child Care Centers* should be attached to this form. Note: Group child care centers and day camps may use their own form.

5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.
   a.
   b.
   c.

6. When to call parents regarding symptoms or failure to respond to treatment.

7. When to consider that the condition requires emergency medical care or reassessment.

8. Additional information that may be helpful to the child care provider.

SIGNATURE – Parent or Guardian	Date Signed (mm/dd/yyyy)
✖	

Review dates: _____ _____ _____ _____ _____

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44192 (Rev. 12/20)

STATE OF WISCONSIN
Wis. Stat. § 252.04

CHILD CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO CHILD CARE CENTER. State law requires all children in child care centers to present evidence of immunization against certain diseases within **30 school days (6 calendar weeks) of admission to the child care center.** These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the child care center. See "Waivers" below. If you have any questions about immunizations, or how to complete this form, please contact your child's child care provider or your local health department.

STEP 1 PERSONAL DATA — PLEASE PRINT

Child's Name(Last, First, Middle Initial)	Date of Birth (Month/Day/Year)	Area Code/Telephone Number
Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)	Address (Street, Apartment number, City, State, Zip)	

STEP 2 IMMUNIZATION HISTORY

List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE A (√) OR (X) except to indicate whether the child has had chickenpox. If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the records.

TYPE OF VACCINE	First Dose Month/Day/Year	Second Dose Month/Day/Year	Third Dose Month/Day/Year	Fourth Dose Month/Day/Year	Fifth Dose Month/Day/Year
Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP, or DT)					
Polio					
Hib (Haemophilus *Influenzae* Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (chickenpox) vaccine Vaccine is required only if the child has not had chickenpox disease.					

Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.

☐ Yes year _____ (Vaccine is not required)

☐ No or Unsure (Vaccine is required)

STEP 3 REQUIREMENTS

The following are the minimum **required** immunizations for the child's age/grade at entry. All children within the range must meet these requirements at child care entrance. Children who reach a new age/grade level while attending this child care must have their records updated with dates of additional required doses.

AGE LEVELS	NUMBER OF DOSES						
5 months through 15 months	2 DTP/DTaP/DT	2 Polio	2 Hib	2 PCV	2 Hep B		
16 months through 23 months	3 DTP/DTaP/DT	2 Polio	3 Hib[1]	3 PCV[2]	2 Hep B	1 MMR[3]	
2 years through 4 years	4 DTP/DTaP/DT	3 Polio	3 Hib[1]	3 PCV[2]	3 Hep B	1 MMR[3]	1 Varicella
At Kindergarten entrance	4 DTP/DTaP/DT[4]	4 Polio			3 Hep B	2 MMR[3]	2 Varicella

[1]If the child began the Hib series at 12-14 months of age, only two doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age (Note: a dose four days or less before the first birthday is also acceptable).

[2]If the child began the PCV series at 12-23 months of age, only two doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required.

[3]MMR vaccine must have been received on or after the first birthday (Note: a dose four days or less before the first birthday is also acceptable).

[4]Children entering kindergarten must have received one dose after the fourth birthday (either the third, fourth or fifth) to be compliant (Note: a dose 4 days or less before the fourth birthday is also acceptable).

STEP 4 COMPLIANCE DATA AND WAIVERS

IF THE CHILD MEETS ALL REQUIREMENTS (sign at STEP 5 and return this form to the child care center), OR

IF THE CHILD **DOES NOT** MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to child care center).

☐ Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received. I, understand that it is my responsibility to obtain the remaining required doses of vaccines for this child **WITHIN ONE YEAR** and to notify the child care center in writing as each dose is received.

NOTE: Failure to stay on schedule or report immunizations to the child care center may result in court action against the parents and a fine of $25.00 per day of violation.

☐ For health reasons this child should not receive the following immunizations _____(List in STEP 2 any immunizations already received)

_____
Physician's Signature Required

☐ For religious reasons this child should not be immunized. (List in STEP 2 any immunizations already received)

☐ For personal conviction reasons this child should not be immunized. (List in STEP 2 any immunizations already received):

STEP 5 SIGNATURE

☒ the best of my knowledge, this form is complete and accurate.

_____ _____
SIGNATURE - Parent, Guardian or Legal Custodian

Clear Form and Reset

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

TRANSPORTATION PERMISSION – CHILD CARE CENTERS

Use of form: Use of this form is voluntary. However, completion of this form will help ensure compliance with portions of DCF 202.08(9), DCF 250.08, DCF 251.08 and DCF 252.09 of the Wisconsin Administrative Codes regarding regularly scheduled, operator / center-provided / center-contracted transportation of children in care. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian should complete this form for placement in the child's file at the center and update the information as needed. The center shall maintain the completed form in the child's file for the duration of the child's enrollment. Note: A copy of this form shall be carried in the vehicle when transporting the child. If the child has special health care needs, also include a copy of DCF-F-CFS-2345, *Health History and Emergency Care Plan*.

A. CHILD INFORMATION

Name	Home Address (Street, City, State, Zip Code)

☐ Yes ☐ No Does the child have any special health care needs? If "Yes", attach the department form, *Health History and Emergency Care Plan*

B. PARENT / GUARDIAN INFORMATION Provide information where the parent / guardian may be reached while the child is in care.

	Name	Home Telephone Number	Work Telephone Number	Cellular Telephone Number
1.				
	Address (Street, City, State, Zip Code)			
2.	Name	Home Telephone Number	Work Telephone Number	Cellular Telephone Number
	Address (Street, City, State, Zip Code)			

C. EMERGENCY CONTACT INFORMATION Provide information on the person to contact if the parent / guardian cannot be reached.

Name	Address (Street, City, State, Zip)	Telephone Number

D. AUTHORIZED DESTINATIONS / PERSONS INFORMATION

	Address Child Transported From (Street, City)	Address Child Transported To (Street, City)	Length of trip one way	Person Authorized to Receive Child
1.				
2.				
3.				
4.				

Procedure to follow when parent / guardian or authorized adult is not at destination to receive child – Specify.

E. CHILD'S HEALTH CARE PROVIDER INFORMATION

Name – Physician	Address (Street, City, State, Zip Code)	Telephone Number

F. AUTHORIZATION

1. ☐ Yes ☐ No I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.
2. ☐ Yes ☐ No I hereby give permission for my school-aged child to enter a building unescorted.

SIGNATURE – Parent / Guardian	Date Signed
✖	

AUTHORIZATION TO ADMINISTER MEDICATION

Youth & Family Department

I HEREBY AUTHORIZE ADMINISTRATION OF THE FOLLOWING MEDICATION(S) TO MY CHILD BY STAFF OF THE KENOSHA YMCA YOUTH & FAMILY DEPARTMENT. (INSTRUCTIONS: Place form in child's file when medication is no longer required.)

Child's Name: _____ D.O.B: _____

Name of Medication	Dosage	Time	Prescription	Dates for Medication to be given
			◯ YES ◯ NO	From: To:
			◯ YES ◯ NO	From: To:
			◯ YES ◯ NO	From: To:
			◯ YES ◯ NO	From: To:
			◯ YES ◯ NO	From: To:
Special Instructions:				
Signature of Parent or Guardian: ✖				**Date Signed:**

Medication Log

Date	Time	Name & Dosage of Medication	Person Administering Medication

Date	Time	Name & Dosage of Medication	Person Administering Medication

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MEDIA RELEASE

From time to time we may take pictures or record video of the children doing activities in our Early Childhood, Before/After School Enrichment or Summer Day Camp programs. We would like permission to use these pictures for sharing what we do here at the YMCA (marketing purposes). Photos and video could be used on our website, social media accounts, newsletters and other print media. We will never reference your child by name or provide specific information regarding your child. We will also never sell ANY pictures or video; they would be used exclusively for YMCA purposes.

Please take a moment to share your preferences regarding media and images of your child.

_____ **YES**, I grant the Kenosha YMCA permission to use **PHOTOS** of my child. I understand the photos maybe shared on the Kenosha YMCA website, in print and on Kenosha YMCA social media pages.

_____ **NO**, please do not take or use any **PHOTOS** of my child.

_____ **YES**, I grant the Kenosha YMCA permission to use **VIDEO** of my child. I understand the photos maybe shared on the Kenosha YMCA website, in print and on Kenosha YMCA social media pages.

_____ **NO**, please do not take or use any **VIDEO** of my child.

Child's Name: _____

Parent's Name (print): _____

Parent Signature: ✖_____

Today's Date:_____

KENOSHA YMCA
7101 53rd Street, Kenosha WI 53144
P 262 654 9622 **F** 262 653 9886
WWW.KENOSHAYMCA.ORG

The Kenosha YMCA (Young Men's Christian Association) is a 501(c)(3) charitable organization under the Internal Revenue Code, thereby qualifying for maximum deductibility. An audit report will be provided upon request.

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Dear Parent/Guardian,

RE: Household Income Statement

The YMCA provides a healthy afternoon snack during our regular after care programs. During our Kids Day Out, Full-Day Camps, Early Childhood Programs and Snow days we provide a healthy and delicious breakfast, lunch and an afternoon snack **(at no additional charge).**

In order for the Kenosha YMCA to receive reimbursement as a participant in the CACFP we need the attached form called "Household Income Statement". This form can returned to the site director at your child's after school program or to the Youth and Family Office.

Sincerely,

The Kenosha YMCA Youth & Famliy Office

Youthandfamily@kenoshaymca.org

262-654-9622 ext. 236

HOUSEHOLD SIZE—INCOME STATEMENT

Child and Adult Care Food Program

An adult household member must complete this form (HSIS) and return it to the center. Complete one HSIS per household.

Refer to the accompanying *Household Letter* for instructions on completing this form.

First and Last Name(s) of Enrolled Child(ren)	Center

PART 1: BENEFITS

If no one receives these benefits, skip to PART 2.

If any member of your household currently receives benefits from:	Check the box for the benefit received AND provide the case number:
FoodShare Wisconsin (10 digit #)	☐ __ __ __ __ __ __ __ __ __ __
Wisconsin Works Cash Assistance (10 digit #)	☐ __ __ __ __ __ __ __ __ __ __
FDPIR (9 digit #)	☐ __ __ __ __ __ __ __ __ __

- DO NOT list a 16 digit Quest Card number *(starts with 5077)* for FoodShare
- Wisconsin Child Care Subsidy is NOT Wisconsin Works Cash Assistance. It does not qualify a participant as free for CACFP.

PART 2: TOTAL HOUSEHOLD SIZE AND INCOME (Complete a, b, and c)

If you completed PART 1, you do not need to list household and income information below.

a) **List full names of all household members below,** including yourself and all children.

Household Member: anyone who is living with you and shares income and expenses, even if not related.

b) **List all income** on the same line as the person who receives it.
- Record each income source only once.
- Check the box for how often each income source is received.

Household Members	(Optional) Age	Check if Foster Child	Check if No Income	Gross wages, Net income (self-employed), Commission, Tips, Cash bonuses, Military pay & allowances for off-site housing/food/clothing, Work comp, strike ben., Unemployment	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually	Pensions, Retirement Social Security, VA benefits, SSI, Disability, Child Support, Adoption assistance, Alimony	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually	Private pensions, Trusts/estates, Annuities, Investments, Interest, Net rental income, Savings withdrawals, Any other income	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐

c) **Record total # of household members:** _______

PART 3: ALL HOUSEHOLDS

ETHNICITY AND RACE DATA COLLECTION – *Completion is optional*

This center is required by Federal law to ask the following two questions concerning ethnicity and race. Your answers are strictly for statistical reporting and will have no effect on determination of eligibility for benefits. **Please answer both questions.**

IS YOUR CHILD(REN) HISPANIC OR LATINO? ☐ Yes, Hispanic or Latino ☐ No, neither Hispanic nor Latino

SELECT ONE OR MORE OF THE FOLLOWING CATEGORIES THAT APPLY TO YOUR CHILD(REN):

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

ADULT HOUSEHOLD MEMBER SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (SS#)

If Part 2 is completed, the adult signing the form must list the last four digits of his/her SS# OR check "None" if he/she does not have a SS#.

I CERTIFY (promise) that all information on this form is true, and that all income is reported unless eligibility is established by receiving FoodShare, WI Works Cash Assistance, and/or FDPIR. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws.

Signature of Adult Household Member	Signature Date *Mo./Day/Yr.*	Last 4 digits of SS# (or check "None" if you do not have a SS#)
		***-**-__ __ __ __ ☐ None

FOR CENTER USE ONLY – Complete all 3 sections and the *Effective Month of Determination*

Section 1: Basis of Determining Eligibility *(A or B)*		Section 2: Eligibility Determination	Section 3: Determining Official's Initials & Approval Date
A. *Household Size & Income*	B. *Benefits/Foster*		______________________
Total Household Size _______	☐ FoodShare WI	☐ Free	****Effective Month of Determination**
	☐ WI Works Cash Assistance	☐ Reduced	
*Total Income $________/_____ ($ Amount) (Time Period)	☐ FDPIR	☐ Non-Needy	______________________
	☐ Foster Child(ren)		Month/Year

*Convert to yearly income only when multiple pay frequencies are reported, using only these multipliers:

Weekly x 52	Twice a month x 24
Every 2 weeks x 26	Monthly x 12

**This form expires one year from the *Effective Month of Determination*.

CHILD AND ADULT CARE FOOD PROGRAM (CACFP) **For Group Child Care & Outside of School Hours Centers**

HOUSEHOLD LETTER (Non-Pricing Programs) **FFY 2021, Rev. 6/20**

Dear Parent or Guardian:

Kenosha YMCA is enrolled in the CACFP, a USDA program which
(Name of Agency)

provides federal assistance dollars to eligible child care centers for serving more nutritious meals. The amount of money our agency receives from this program is based on the income levels of our families. **In order to continue providing a quality meal service without additional charge, we request every family of our enrolled children to complete new a Household Size-Income Statement form (HSIS) each year**. **Please complete and return the attached HSIS form to our office. This information will be kept strictly confidential in our files.** Only one completed HSIS is required for all children in your household. Once we have properly approved your HSIS as eligible, our agency will receive the higher *("Free" or "Reduced-price")* meal reimbursement rates for your enrolled children, for 12 months from the *Effective Month of Determination* regardless of any change in your household size and/or income or termination from Benefits Programs.

- You are not required to complete this HSIS if no one in your household receives benefits from FoodShare WI (the Supplemental Nutrition Assistance Program (SNAP)), FDPIR (Food Distribution Program on Indian Reservations), Wisconsin Works Cash Assistance Programs and your household income is higher than the amount shown for your household size within the table below. In this case, however, we would appreciate you returning the HSIS to us with "N/A" written on it along with your signature and date.

Determining Eligibility based on Participation in Benefits Programs → *Complete Part 1 and Part 3 of HSIS form*

Our agency receives the Free meal reimbursement rate for children in households receiving benefits from FoodShare WI, FDPIR, or WI Works Cash Assistance. **Wisconsin Works Cash Assistance** is Wisconsin's Temporary Assistance for Needy Families (TANF) program. **It provides temporary cash assistance through work placement and training programs and IS NOT the WI Child Care Subsidy Program.** WI Works Cash Assistance Programs include Trial Employment Match Program (TEMP), Community Service Jobs (CSJ), W-2 Transitions (W-2T), Custodial Parent of an Infant (CMC), Minor Parents Services, Noncustodial Parents, and Pregnant Women.

You must include the following information on the HSIS (a-c) for eligibility based on receiving benefits from FoodShare WI, FDPIR, WI Works Cash Assistance:

(a) The names of your enrolled children;

(b) Checked box for the benefit your household receives and its case number; &

(c) The signature of an adult member in the household & signature date

- DO NOT list case numbers for: Medicaid, SSI, OR Wisconsin Child Care Subsidy program AND
- DO NOT list a 16 digit Quest Card number *(starts with 5077)* for FoodShare WI

Determining Eligibility by Household Size and Income → *Complete Part 2 and Part 3 of HSIS form*

Household-Size Income Scale (Effective July 1, 2020 to June 30, 2021)

Household Size	Annual Income Level (at or below)
1	$ 23,606
2	$ 31,894
3	$ 40,182
4	$ 48,470
5	$ 56,758
6	$ 65,046
7	$ 73,334
8	$ 81,622
For each additional Household Member, add:	+$ 8,288

If your household earns a total income that is less than or equal to the income levels listed within this table, we will receive higher meal reimbursement rates *("Free" or "Reduced-price" meal rate)* for your children.

For determining eligibility based on your household size and income, you must include the following information on the HSIS (a-e):

(a) Full names of all household members who share income and expenses, including children, parents, and non-related persons;

(b) Income received by each household member identified by source of income and its pay frequency;

(c) Total number of household members;

(d) The signature of an adult member of the household and signature date; and

(e) The last four digits of the social security number of the adult household member signing the HSIS or an indication he/she does not have a social security number.

- Disclosure of United States citizenship or immigration status is not required and is not a condition of eligibility for higher meal reimbursement rates.

Eligibilities of Foster, Runaway, Homeless, and Migrant Children, and Children enrolled in Head Start: Our agency will receive the Free meal reimbursement rates for foster, runaway, homeless, and migrant children and children enrolled in Head Start who reside in your household, when you provide the respective documentation listed below.

- Please note: These children's **eligibility for Free meals does not extend to other children in your household.**

The respective documentation is required for these children to be eligible for Free Meals:

- **Foster children:** Your completed HSIS with the 'Foster Child' box checked next to your foster children's names. When including them on your HSIS completed for your non-foster children, any income reported for your foster children must only be for their personal use. Your foster children will then be eligible at the "Free" meal rate. Your non-foster children's eligibilities will be based on the benefits or income information provided on your household's completed HSIS form.
- **Children Enrolled In Head Start:** Written certification of your child's Head Start enrollment eligibility period from the Head Start administering agency.
- **Runaway, Homeless, and Migrant Children:** Written certification of the child's status from an official of the appropriate Runaway and Homeless Youth Program, Migrant Education Program, or school official.

Use of Information Statement: The Richard B. Russell National School Lunch Act requires the information on this form. You are not required to provide this information, but if you do not, our agency cannot receive higher reimbursement rates for meals served to your children. You must include the last four digits of the social security number of the household member signing the form unless: the HSIS is only for your foster child(ren); you list a case number for receiving benefits from FoodShare WI, WI Works Cash Assistance, or FDPIR; or when the household member signing the HSIS checks "None" for not having a SS#.

Sharing Eligibility Information: Children's eligibility information may be shared in accordance with disclosure protection requirements without prior notification, with education, health, and nutrition programs to assess their eligibility for benefits. The law allows us to share your children's eligibility information with programs such as Medicaid or BadgerCare for ensuring their access to free or low cost health insurance, **unless you tell us not to**. This information may only be used for determining eligibility for their programs; if your children are eligible, they may contact you to offer their enrollment options. Please note that filling out this HSIS does not automatically enroll your children in these programs. **If you do not want your information to be shared with these programs, please notify us in writing. This notification will not change whether your children's meals are eligible for meal reimbursement.** Your eligibility information provided on the HSIS may also be shared with auditors for program reviews and law enforcement officials for the purpose of investigating violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) Mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) Fax:(202) 690-7442; or (3) Email: program.intake@usda.gov This institution is an equal opportunity provider.

Dr. M. Rachel Mall, EdD

Signature of Agency Representative