FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

ENSURE A BRIGHTER FUTURE

Y Preschool & Early Childhood Education Enrollment Packet, 2022-2023
KENOSHA YMCA

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Early Childhood Program

Dear Parents,

Thank you for choosing the Kenosha YMCA Youth & Family Program for your childcare needs.

Registration is available on our website **at KENOSHAYMCA.ORG**
If you already have an account with us please log in. If you do not have a YMCA account, please create one for you and your children you are enrolling.

1. **Once you are logged onto your account choose "Classes" and "Early Childhood".**

2. **Select the correct program by clicking on either our Tykes & Tots for ages 2-3yr old or our Y Preschool for ages 4-5yr. Next click on "Enroll Now".**

3. **Select your child to Enroll in the drop box.**

4. **Next the school calendar will be available for you to choose the days you need care. Your choices are Full Day Care and Half Day Care (Under 5 hours and preferably from 7am to 12 pm).**

This packet contains forms that must be filled out for your registration to be complete:

- Enrollment Forms
- Immunization Record (all ages) and Health Report (4yrs and younger)
- Household Size Income Statement Signed and Dated / CACFP Information
- Authorization to Administer Medication if Applicable

Please bring these forms to the program you are enrolling your child in or to the Membership Desk at the Kenosha YMCA.

If you have any questions, please contact Jessica Brown (Early Childhood Director) jbrown@kenoshaymca.org or 262.654.9622 ext. 217).

We look forward to building relationships with your kids and helping to meet the needs of your family.

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

Kenosha YMCA Early Childhood Program
2022-2023

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 One	**First Day of Attendance** / /	**Last Day of Attendance** / /
Address (City, State & Zip code required)	Telephone #	DOB	Age

Program Attending:
Select One

PARENT OR GUARDIAN (provide the information requested for EACH parent or guardian.)
NOTE: All parents/guardians will be permitted to visit during center hours and pick up the child 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: (select one) ◯ 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:

✖ _____
Signature of Parent or Guardian Date

PHYSICIAN & MEDICAL FACILITY INFORMATION

Physician Name	Address	Phone #

Preferred Medical Facility - Please select one or write in 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.

✖ _____
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 have been informed of pets in the center and their degree of contact with the enrolled children. ◯ **YES** ◯ **NO**

Note: If pets are added after a child is enrolled, parents shall be notified in writing prior to the pet's addition to the center.

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.

✖ _____
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.

	Brand Name	Ingredient Strength
☐ 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.		
☐ 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: _____ _____ _____ _____ _____

2022-2023 Annual Attendance & Payment Contract

Early Childhood Program

Child's Name: _____ **Child's Age:**_____

1. I understand that the hours listed below are my contracted days and I am responsible for bi-weekly payments of contracted fees despite actual attendance. Additional charges will apply for additional days, however. Fees not paid in advance will result in declined services. Failure to abide by this may also result in additional fees. **I understand I will not receive adjustments in fees for absences, illnesses, and emergency/weather related closures (unless approved by the Early Childhood Coordinator).**

2. I understand if my schedule and child care needs change, I will need to fill out a new Contract. I also understand if my schedule changes often enough I may be asked to use Monthly Payment Schedules and forfeit the benefits of an Annual Attendance Agreement.

3. **I am aware of my child's scheduled hours at the center and agree to bring and sign my child in and out on time and call in the event that my child will be absent.**

4. A written notice from the parent/guardian of withdrawal from the center is required at least two weeks prior to the last day of attendance. Failure to comply will result in a two week surcharge.

5. I understand that I will earn **5 flex days and 3 sick days per school year**, per child after the first month of attendance. I will attempt to give a two week notice prior to using any flex days and a doctor's note for sick days. Unused days will not be carried forward to the following year's allotment. Refunds will not be issued in exchange for flex days. If my schedule changes often, I understand I forfeit my flex days and will be required to fill out a Monthly Payment Schedule.

6. My child's enrollment may be terminated for failure to abide by this contract, failure to pay fees by required due date, failure to follow center policies and procedures as outlined in the Policy & Information Booklet or failure to comply with DHFS license requirements.

7. I understand that the services indicated below are my child's contracted services in the Early Childhood Program:

Fees based on individual child care needs. Minimum of 2 options required.
Member or Multiple child/ General Public Rate *Schedule your child ONLINE.

PROGRAM	2 -31/2 years	3 1/2-5 years	MON	TUES	WED	THURS	FRI
Half Day	$29/$34	$26/$31	○ Half Day ○ Full Day **Arrival Time:**	○ Half Day ○ Full Day **Arrival Time:**	○ Half Day ○ Full Day **Arrival Time:**	○ Half Day ○ Full Day **Arrival Time:**	○ Half Day ○ Full Day **Arrival Time:**
Full Day	$41/$46	$38/$43	**Departure Time:**	**Departure Time:**	**Departure Time:**	**Departure Time:**	**Departure Time:**

Parent/Guardian Signature: ✖_____ Date: _____

Office Use Only: Enter date the sick/ vacation day was used. Flex Day **1**_____**Flex Day 2**_____**Flex Day 3**_____
Flex Day 4_____**Flex Day 5**_____**Sick Day 1**_____**Sick Day 3**_____ **Sick Day 3**_____

2022-2023 Policy & Transportation Agreement

Youth & Family Department

Child's Name: _____

A. Policy Agreement

_____ **(initials)** I have read the Kenosha YMCA Program Policy booklet and agree to abide by the policies stated therein. This includes paying weekly fees 2 weeks BEFORE services are rendered OR Wisconsin Shares copays. **I understand services will be declined without payment.**

B. Agreement To Participate On-Site

_____ **(initials)** I will transport and sign my child in/out of the Kenosha YMCA Early Childhood Program on the days I have indicated on the Annual Attendance Agreement/Monthly Payment Schedule.

C. Agreement To Participate & Transportation Agreement to the Kenosha YMCA

_____ **(initials)** I will allow the Kenosha YMCA to transport my child to and from the Kenosha YMCA during the Early Childhood Program hours on Field Trip Days. **I give permission for my child to attend ALL activities.**

D. Parent Swimming Assessment

_____ **(initials)** I have observed that my child _____,

has the following swimming ability.

_____ Cannot Swim _____ Beginner Swimm_____ Intermediate Swim_____ Strong Swimme

(↑ Please √ check mark the most accurate assessment ↑)

Additional swimming information: _____

_____

_____

Please share your email address with us for important program updates as well as online payment sign up.

Parent/Guardian Email Address: _____

✖ _____

Signature of Parent or Guardian **Date Signed**

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

CHILD HEALTH REPORT – CHILD CARE CENTERS

Use of form: Use of this form is voluntary; however, completion of this form meets the requirements of DCF 202.08(4), DCF 250.04(6)(a)4. and DCF 251.04(6)(a)8. Failure to comply with these rules 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: Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months thereafter. Each child 2 years of age but who is not 5 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years thereafter. The parent / guardian shall give this form to the physician, physician assistant, or other EPSDT provider to be completed, signed, and dated. The licensee / operator shall obtain a copy for the child's record. Note: Children are also required to have on file at the child care center documentation of immunizations; it may be helpful if the parent / guardian includes a copy of the child's immunization record when submitting this form to the child care center.

PARENT OR GUARDIAN – This section should be completed by the parent or guardian

Child's Name (Last, First, MI)	Child's Birthdate (mm/dd/yyyy)

Child's Address (Street, City, State, Zip Code)

Parent or Guardian Name (Last, First, MI)

Parent or Guardian Address (Street, City, State, Zip Code)

HEALTH PROFESSIONAL – This section should be completed by the health professional

Instructions for feeding and care of child with special health concerns – Specify: (attach information as necessary).

☐ Yes ☐ No Does the child have a milk allergy? If "Yes," identify the recommended milk substitute.

☐ Yes ☐ No Does this child have any food or non-food allergies? If "Yes," specify and include the treatment plan to be implemented in the event of an allergic reaction.

Date of child's most recent blood lead test: _____ (mm/dd/yyyy).

Note: Children on Medicaid are required to be tested at around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented. Lead testing is optional for children who are not on Medicaid.

Immunization(s) not to be administered to child due to medical reason(s) – Specify.

AUTHORIZATION

I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.

Name – MD, PA, or other EPSDT Provider (type or print)	Address (Street, City, State, Zip Code)

SIGNATURE – MD, PA, or other EPSDT Provider	Date of Examination
X	

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-04020L (Rev. 6/2020)

STATE OF WISCONSIN
Wis. Stat. §§ 252.04 and 120.12 (16)

STUDENT IMMUNIZATION RECORD

INSTRUCTIONS TO PARENT: COMPLETE AND RETURN TO SCHOOL WITHIN **30 DAYS AFTER ADMISSION.** State law requires all public and private school students to present written evidence of immunization against certain diseases **within 30 school days of admission.** The current age/grade specific requirements are available from schools and local health departments. These requirements can only be waived if a properly signed health, religious or personal conviction waiver is filed with the school. The purpose of this form is to measure compliance with the law and will be used for that purpose only. If you have questions regarding immunizations, or how to complete this form, contact your child's school or local health department.

Step 1 **PERSONAL DATA** **PLEASE PRINT**

Student's Name	Birthdate (MM/DD/YYYY)	Gender Select One	School	Grade	School Year

Name of Parent/Guardian/Legal Custodian	Address (Street, City, State, Zip)	Telephone Number

Step 2 **IMMUNIZATION HISTORY**

List the MONTH, DAY, AND YEAR your child received each of the following immunizations. DO NOT USE A (√) OR (X) except to answer the question about chickenpox, Tdap, or Td. If you do not have an immunization record for this student at home, contact your doctor or public health department to obtain it.

TYPE OF VACCINE*	FIRST DOSE MM/DD/YYYY	SECOND DOSE MM/DD/YYYY	THIRD DOSE MM/DD/YYYY	FOURTH DOSE MM/DD/YYYY	FIFTH DOSE MM/DD/YYYY
DTaP/DTP/DT/Td (Diphtheria, Tetanus, Pertussis)					
Adolescent booster (Check appropriate box) ____ Tdap ____ Td					
Polio					
Hepatitis B					
MMR (Measles, Mumps, Rubella)					
Varicella (Chickenpox) Vaccine *Vaccine is required only if your child has not had chickenpox disease. See below:*					

Has your child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known:
◯ YES _____ Year (Vaccine not required)
◯ NO or Unsure (Vaccine required)

Has your child had a blood test (titer) that shows immunity (had disease or previous vaccination) to any of the following? (Check all that apply)
Varicella Measles Mumps Rubella Hepatitis B
If YES, provide laboratory report(s)

Step 3 **REQUIREMENTS**

Refer to the age/grade level requirements for the current school year to determine if this student meets the requirements.

Step 4 **COMPLIANCE DATA**

STUDENT MEETS ALL REQUIREMENTS
Sign at Step 5 and return this form to school.

Or

STUDENT DOES NOT MEET ALL REQUIREMENTS

Check the appropriate box below, sign at Step 5, and return this form to school. PLEASE NOTE THAT INCOMPLETELY IMMUNIZED STUDENTS MAY BE EXCLUDED FROM SCHOOL IF AN OUTBREAK OF ONE OF THESE DISEASES OCCURS.

Although my child has **NOT** received **ALL** the required doses of vaccine, the FIRST DOSE(S) has/have been received. I understand that the SECOND DOSE(S) must be received by the 90th school day after admission to school this year, and that the THIRD DOSE(S) and FOURTH DOSE(S) if required must be received by the 30th school day next year. I also understand that it is my responsibility to notify the school in writing each time my child receives a dose of required vaccine.

NOTE: Failure to stay on schedule may result in exclusion from school, court action and/or forfeiture penalty.

WAIVERS (List in Step 2 above, the date(s) of any immunizations your child has already received)

For health reasons this student should not receive the following immunizations _____

✖ _____ _____
SIGNATURE - Physician Date Signed

For religious reasons, I have chosen not to vaccinate this student with the following immunizations (check all that apply)
DTaP/DTP/DT/Td Tdap, Polio Hepatitis B MMR (Measles, Mumps, Rubella) Varicella

For personal conviction reasons, I have chosen not to vaccinate this student with the following immunizations (check all that apply)
DTaP/DTP/DT/Td Tdap Polio Hepatitis B MMR (Measles, Mumps, Rubella) Varicella

Step 5 **SIGNATURE**

This form is complete and accurate to the best of my knowledge. Check one: (**I do** ◯ **I do not** ◯) give permission to share my child's current immunization records and as they are updated in the future with the Wisconsin Immunization Registry (WIR). I understand that I may revoke this consent at any time by sending written notification to the school district. Following the date of revocation, the school district will provide no new records or updates to the WIR.

✖ _____ _____
SIGNATURE - Parent/Guardian/Legal Custodian or Adult Student Date Signed

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

What Parents Need To Know About MyWIChildcare

The Department of Children and Families (DCF) has changed the way it pays for subsidized child care. The MyWIChildcare EBT card put the payment responsibility into the hands of the parents, instead of the state. Parents can now see the total amount of Wisconsin Share Subsidy, will be aware of the full cost of child care, and are responsible for any additional money owed to the child care provider.

Parents will need to:

The Kenosha YMCA charges monthly according to your child's schedule. Please refer to your monthly payment contract or your Annual Attendance Contract for our fees and what your charges will be every month. We have a Payment Due Dates Schedule to reference as well.

- If your subsidy amount doesn't cover the full cost of child care, you are responsible for paying the balance owed to the Kenosha YMCA.
- Your EBT card will be reloaded with funds on the **1st** of every month. You must pay the monthly fees using your EBT card online or over the phone by the **5th** of every month. If you do not make an EBT payment to the YMCA by the 5th of every month you will be charged a $5.00 late payment fee. Your co pays will be due according to the payment schedules.

- **You only pay what is due for the month to the Kenosha YMCA. Each month may vary depending on school schedules such as half days/early release and non-school days.**

Provide their work and or school schedules in to get an authorization:

- If you have a schedule change, new home address, change in income or a change in your household size notify your child care worker within 10 calendar days.

Request extra child care if it is needed, when school is closed:

- Know your child's school schedule and school closed days. The YMCA does not charge for school closed days on our monthly contract. However, if care is needed you must fill out a separate registration for these school closed days and are charged once your child is registered. Space is limited on these school closed days we call KDO's and Camps.

If you have any questions/concerns please contact our Youth and Family Office at 262-654-9622 ext. 236 and or/ Lisa Eckardt at leckardt@kenoshaymca.org

CHILD AND ADULT CARE FOOD PROGRAM (CACFP) **For Group Child Care & Outside of School Hours Centers**
HOUSEHOLD LETTER (Non-Pricing Programs) **FFY 2023, Rev. 6/22**

Dear Parent or Guardian:

_____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 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 Programs. **Wisconsin Works Programs** 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 Programs include Trial Employment Match Program (TEMP), Community Service Jobs (CSJ), Case Management, 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 Programs:

(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 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, 2022 to June 30, 2023)

Household Size	Annual Income Level (at or below)
1	$ 25,142
2	$ 33,874
3	$ 42,606
4	$ 51,338
5	$ 60,070
6	$ 68,802
7	$ 77,534
8	$ 86,266
For each additional Household Member, add:	+$ 8,732

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. **The respective documentation is required for these children to be eligible for Free Meals: These children's eligibility for Free meals does not extend to other children in your household.**

- **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 Programs, 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. 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, 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.

Refer to the USDA Non-Discrimination Statement and Complaint Filing Procedure (https://dpi.wi.gov/nutrition#discrimination).
This institution is an equal opportunity provider.

_____
Signature of Agency Representative

CACFP Wisconsin – Child and Adult Care Food Program

Group Child Care & Outside of School Hours Centers — FFY 2023, rev. 6/22

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

Do any household members currently participate in FoodShare WI, WI Works Programs, or FDPIR?
If yes, check the program and write the corresponding case number below; then go to Part 3. If no, skip to Part 2.

☐ **FoodShare Wisconsin (10-digit case number):**
DO NOT list a 16-digit Quest Card number:
____

☐ **FDPIR (9-digit case number):**
____

☐ **Wisconsin Works (W-2) Programs (10-digit case number):**
Wisconsin Shares Child Care Subsidy benefits is NOT a W-2 Program. It does not qualify a child as free in the CACFP.
____

PART 2: HOUSEHOLD SIZE AND INCOME

If you did not complete PART 1, complete a, b, and c below; then go to PART 3.

a) **Household Members Information:**
List full names of all members in first column, including yourself and all children.

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 Member Names — **Household Member:** anyone who is living with you and shares income and expenses, even if not related.	(Optional) Age	Check if Foster Child	Check if No Income	Gross wages, Net income (self-employed), Tips, Commission, Cash bonuses, Military pay & allowances, Work comp, Unemployment	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually	Retirement, Social Security, SSI, Disability, VA benefits, Child Support, Alimony	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually	Private pensions, Trusts, 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: SIGNATURE

An adult household member must sign and date this form
If PART 2 is completed, the adult signing the form **must list the last four digits of their SS#** OR check "None" if they do not have a SS#.

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

I CERTIFY that all information on this form is true. I understand that this information is given in connection with the receipt of Federal funds and that CACFP officials may verify the information. I am aware that if I purposely give false information, my children 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

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

*Convert to yearly income <u>only</u> when multiple pay frequencies are reported, using only these multipliers:	Weekly x 52 Every 2 weeks x 26	Twice a month x 24 Monthly x 12	**This form expires one year from the *Effective Month of Determination.*

This institution is an equal opportunity provider.