



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

QUALITY CARE WHEN YOU CAN'T BE THERE

**Before & After School Enrichment Program (BASE)
Enrollment Packet, 2023-2024**

KENOSHA YMCA





FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

ONLINE SCHEDULING

See below for directions on accessing/creating your account

LOGGING INTO YOUR ACCOUNT.....

CURRENT MEMBERS & YOUTH AND FAMILY PARTICIPANTS

- Visit KenoshaYMCA.org and click 'Account Log In' or [CLICK HERE to access Online Registration.](#)
- Click 'SIGN IN' button if you already have an account or choose "Create an Account".
- Once logged onto your account choose at the top "classes" and then choose "Before and After School Enrichment"
- Select your child's school (location).
- Click "Enroll"
- Choose "Child"
- Click "Continue"
- You may schedule your child by choosing the dates of care:

Annual Contract = Block Batching Option

Follow instructions highlighted in yellow.

Monthly Attendance Agreement & Occasional Care

Select days of care needed on monthly calendars

**Be sure to select "First Hour" OR "After Care" if care is needed in the afternoon. Do not select both.*

- Once you have completed selecting your days, hit "Add to Cart". If you have more than one child you will need to return to the "Classes" tab and select the next child to enroll.
- Select "Check Out"
- You will then see your payment plan and after you check out you will be prompt to enter your credit card information. The card you use at "check out" will be charged on the payment due dates listed on your payment plan,
- **Your child is officially enrolled once all forms are complete and your child's schedule online and fees are paid.**
- Forms can be dropped off at the Kenosha YMCA Member Service Desk or emailed to youthandfamily@kenoshaymca.org.

Should you have difficulties you may contact either your Site Director or the Youth & Family Office at 262.654.9622 ext. 236

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®
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Dear Parents,

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

We will require for you and all of your authorized family and friends to receive a Youth and Family Pick Up Pass in order to enter our YMCA to drop off or pick up your child(ren) to/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 school. If you enroll your child(ren) for future Youth and Family Programs such as our Summer Camp Program, we will adjust the expiration date for you and make any adjustments you request.

If you already received a pass during our Summer Camp Program you do not need to stop by the desk unless we need to make changes.

Sincerely,

Youth and Family Office

youthandfamily@kenoshaymca.org

262-654-9622 ext. 207



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
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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.

<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to apply sunscreen to my child.	Brand Name	Ingredient Strength
<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to allow my child to self-apply sunscreen.		
<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to apply repellent to my child.	Brand Name	Ingredient Strength
<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to allow my child to self-apply repellent.		

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.

- | | | |
|---|--|---|
| <input type="checkbox"/> No specific medical condition | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gastrointestinal or feeding concerns, including special diet and supplements |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy / seizure disorder | <input type="checkbox"/> Any disorder, including Cognitively Disabled, LD, ADD, ADHD, or Autism |
| <input type="checkbox"/> Cerebral palsy / motor disorder | | |
| <input type="checkbox"/> 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: _____



2023-2024 Policy and 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 BASE 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 the Callahan Family Branch during the BASE Program hours on the days indicated/posted at the school my child attends. **I give permission for my child to attend ALL activities.**

D. Parent Swimming Assessment

(must be completed in order for your child to be able to swim at the Kenosha YMCA while in the BASE Program)

_____ (initials) I have observed that my child _____, has the following swimming ability.

Cannot Swim Beginner Swimmer Intermediate Swimmer Strong Swimmer

(↑ 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



2023-2024 Alternate Arrival / Release Agreement

Youth & Family Department

Instructions: Complete this form for placement in your child's file when your child will arrive at the center from school, home or other activities, or depart from the center to go to school, home or other activities, and your child **will not** be accompanied by a parent or other previously authorized person or transported by the center. This form should be updated as information changes. Periodic review with the parent / guardian is possible.

RELEASE INSTRUCTIONS

My child _____
(Child's Name)

will leave _____ **KENOSHA YMCA BEFORE & AFTER SCHOOL PROGRAM** _____
(Program Name)

by way of _____ **WALKING TO CLASS** _____
(Walking, bicycle, bus, car pool, etc BE SPECIFIC)

to go to _____
(Name of your child's teacher)

at _____ **A.M.** OR **P.M.**
(Time of departure)

on **Mon** **Tues** **Wed** **Thurs** **Friday**
(Select the days of the week)

(initials) **I understand my child will leave from this destination without center supervision.**

ARRIVAL INSTRUCTIONS

My child _____
(Child's Name)

will arrive at _____ **KENOSHA YMCA BEFORE & AFTER SCHOOL PROGRAM** _____
(Program Name)

from _____
(Name of your child's teacher)

by way of _____ **WALKING FROM CLASS** _____
(Walking, bicycle, bus, car pool, etc BE SPECIFIC)

at _____ **A.M.** OR **P.M.**
(Time of arrival)

on **Mon** **Tues** **Wed** **Thurs** **Friday**
(Select the days of the week)

(initials) **I understand my child will arrive from this destination without center supervision.**

ADDITIONAL INSTRUCTIONS

I give permission for my child to be released for the following activities (initial each): **Breakfast** _____

Intramurals _____ **School Club (please specify)** _____ **Tutoring** _____

Safety Patrol _____ **End of morning program in care of playground attendants** _____

Assisting in the classroom _____ **Other Activity as specified** _____

I understand that I am responsible for notifying the Kenosha YMCA Before & After School Program of any changes in this schedule such as vacation, school conference days, etc.



Signature of Parent or Guardian

Date Signed



2023-2024 Annual Scheduling & Payment Contract

Youth & Family Department

Child's Name: _____ **School:** _____

1. I that I am responsible for payments of fees despite actual attendance. If I add on extra days of care from my original schedule charges will apply for additional day. Fees not paid in advance will result in declined services unless arrangements have been made with the Site Director, Assistant Director, or Youth and Family Department Director. I understand I will not receive adjustments in fees for absences that do not meet the approved criteria (see Sick Day and Snow Day policies).
2. I understand if my schedule and child care needs change, I will need to inform the Site Director. I also understand if my schedule changes often enough I may be asked to use Flexible Scheduling option and forfeit the benefits of Annual Scheduling.
3. **I am aware of my child's scheduled hours at the center and agree to bring and sign my child in and out 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 per school year, per child after the first month of attendance and 3 sick days. Sick days require a doctor's note and proof of child's absence from school.** I will give a two week notice prior to using any flex 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 more than 2 times in a given month, I understand I forfeit my flex days and will be required to change to the Flexible Scheduling option.
6. My child's enrollment may be terminated if I neglect to abide by this contract, do not pay fees by required due date, do not adhere to the center policies and procedures as outlined in the Policy & Information Booklet or do not comply with DHFS license requirements.
7. I understand that the services indicated online are my child's contracted services in the Before & After School Enrichment Program.

2023-2024 BASE Fees		Scheduling of Days of Care are done ONLINE. A payment plan will be created.	
Before School	\$8.00	Per Day	
First Hour After	\$9.00	Per Day	
After School	\$13.00	Per Day	
Fridays & Early Release	\$18.50	Per Day	
<p><small>*Multiple Child(ren) will receive a 10% discount after the first child is enrolled and each child after. Separate Registration for Non School Days @ \$30.00 per day is available online under "Before & After Care" and listed as "Kid's Day Out".</small></p>			

By signing below, I agree to adhere to the above Annual Scheduling & Payment Contract and will take the appropriate steps if other arrangements need to be made.



Signature of Parent or Guardian

Date Signed

Office use only:

Sick Day 1:	Sick Day 2:	Sick Day 3:	Flex Day 1:	Flex Day 2:	Flex Day 3:	Flex Day 4:	Flex Day 5:

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.

PERSONAL DATA

PLEASE PRINT

STEP 1	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)	

IMMUNIZATION HISTORY

STEP 2 List the MONTH, DAY AND YEAR the child received each of the following immunizations. 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 <i>Influenzae</i> Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (Chickenpox)					

History of Varicella/Chickenpox

In accordance with DHS 144.03(2)(g), I attest that this child has a reliable history of varicella disease and is not required to receive Varicella vaccine.

SIGNATURE – Physician/PA/APNP
Date Signed

REQUIREMENTS

STEP 3 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

¹If 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).

²If 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.

³MMR 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).

⁴Children 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).

COMPLIANCE DATA AND WAIVERS

STEP 4 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):

SIGNATURE

STEP 5 To the best of my knowledge, this form is complete and accurate.

SIGNATURE - Parent, Guardian or Legal Custodian
Date Signed



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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 may be shared on the Kenosha YMCA website, in print and on Kenosha YMCA social media pages.

YES, my child's photos may be used and displayed in the classroom (art projects, group class photos, etc) **BUT** do not share my child's photos online, on social media, or in print advertisements.

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 videos may be 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: ~~X~~ _____

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.





What Parents Need To Know About MyWICchildcare

The Department of Children and Families (DCF) has changed the way it pays for subsidized child care. The MyWICchildcare 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

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
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PART 1: BENEFITS

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

If any member of your household currently receives benefits from:

FoodShare Wisconsin (10 digit #) <input type="checkbox"/>	Check the box for the benefit received AND provide the case number: _____	<ul style="list-style-type: none"> 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.
Wisconsin Works Cash Assistance (10 digit #) <input type="checkbox"/>	_____	
FDPIR (9 digit #) <input type="checkbox"/>	_____	

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.

<p>a) List full names of all household members below, including yourself and all children.</p> <p>Household Member: anyone who is living with you and shares income and expenses, even if not related.</p>	<p>b) List all income on the same line as the person who receives it.</p> <ul style="list-style-type: none"> Record each income source only once. Check the box for how often each income source is received. 																																																																																																																																																																																				
	<table border="1" style="width:100%; border-collapse: collapse; font-size: 8px;"> <thead> <tr> <th rowspan="2">Household Members</th> <th rowspan="2">Age (Optional)</th> <th rowspan="2">Check if Foster Child <input type="checkbox"/></th> <th rowspan="2">Check if No Income <input type="checkbox"/></th> <th rowspan="2">Gross wages, Net income (self-employed), Commission, Tips, Cash bonuses, Military pay & allowances for off-site housing/food/clothing, Work comp, strike ben., Unemployment</th> <th>Weekly</th> <th>Every 2 Weeks</th> <th>Twice per Month</th> <th>Monthly</th> <th>Annually</th> <th rowspan="2">Pensions, Retirement Social Security, VA benefits, SSI, Disability, Child Support, Adoption assistance, Alimony</th> <th>Weekly</th> <th>Every 2 Weeks</th> <th>Twice per Month</th> <th>Monthly</th> <th>Annually</th> <th rowspan="2">Private pensions, Trusts/estates, Annuities, Investments, Interest, Net rental income, Savings withdrawals, Any other income</th> <th>Weekly</th> <th>Every 2 Weeks</th> <th>Twice per Month</th> <th>Monthly</th> <th>Annually</th> </tr> <tr> <th><input type="checkbox"/></th> <th><input type="checkbox"/></th> <th><input type="checkbox"/></th> <th><input type="checkbox"/></th> <th><input type="checkbox"/></th> <th><input type="checkbox"/></th> <th><input type="checkbox"/></th> <th><input type="checkbox"/></th> <th><input type="checkbox"/></th> <th><input type="checkbox"/></th> <th><input type="checkbox"/></th> <th><input type="checkbox"/></th> <th><input type="checkbox"/></th> <th><input type="checkbox"/></th> <th><input type="checkbox"/></th> <th><input type="checkbox"/></th> <th><input type="checkbox"/></th> <th><input type="checkbox"/></th> <th><input type="checkbox"/></th> <th><input type="checkbox"/></th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>\$</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input 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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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input 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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#) ***_**_ _ _ _ <input type="checkbox"/> None
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FOR CENTER USE ONLY – Complete all 3 sections and the Effective Month of Determination

<p>Section 1: Basis of Determining Eligibility (A or B)</p> <p>A. Household Size & Income Total Household Size _____</p> <p>*Total Income \$ _____ / _____ (\$ Amount) (Time Period)</p>	<p>Section 2: Eligibility Determination</p> <p><input type="checkbox"/> Free <input type="checkbox"/> Reduced <input type="checkbox"/> Non-Needy</p>	<p>Section 3: Determining Official's Initials & Approval Date</p> <p>_____</p> <p>**Effective Month of Determination</p> <p>_____</p> <p style="text-align: center;">Month/Year</p>
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*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.

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)), FDIPIR (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, FDIPIR, 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, FDIPIR, WI Works Cash Assistance:**

- (a) The names of your enrolled children;
 - **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**
- (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

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 FDIPIR; 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.

Signature of Agency Representative