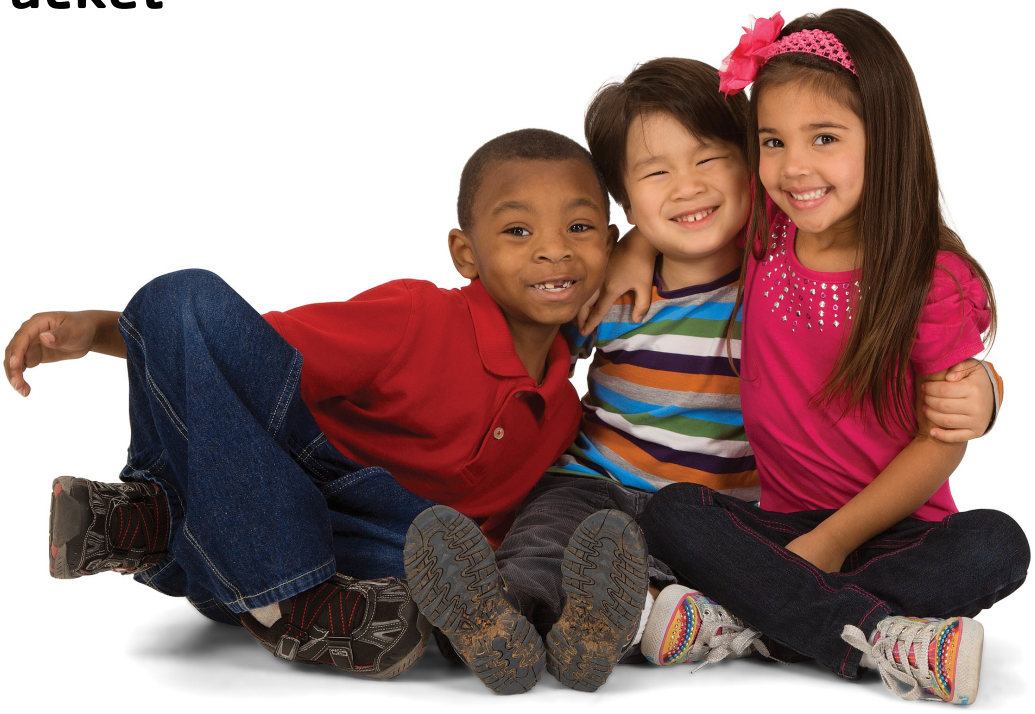
FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

ENSURE A BRIGHTER FUTURE

Y Preschool and Summer Camp/ Early Childhood Enrollment Packet

2023-2024



FOR YOUTH DEVELOPMENT®
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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.** **CLICK HERE to access Online Registration.**
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 , Y Preschool for ages 3 1/2-5yr or our 4-5 yr old Summer Camp Program. 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, Half Day Care and all day Summer Camp.**

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 our Youth and Family Office at 262-654-9622 ext. 236

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 2023-2024

7101 53rd St. Kenosha, WI 53144 • 262-654-9622 • www.kenoshaymca.org

Please complete online and print to sign OR print to fill out in Blue or Black Ink ONLY!

FOR OFFICE USE ONLY

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

Select Classroom Per Age of Child: ◯ **Tykes & Tots ages 2-3 yrs** ◯ **Y Preschool and Summer Camp ages 4-5 yrs**

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: Attach a copy of your current court order

✕ _____

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.

✕ _____

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 Center. ◯ YES ◯ NO

I will be receiving state assistance (Wisconsin Shares) towards childcare fees and will be responsible for any CoPays: ◯ 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.

Signature of Parent or Guardian **Date**

✕

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)
X	

Review dates: _____ _____ _____ _____ _____

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44192 (02/2023)

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. 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)					

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

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

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

X _____ _____

SIGNATURE - Parent, Guardian or Legal Custodian 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 required unless the health examination report is on an electronic printout from a licensed physician, physician assistant, or other EPSDT provider. 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

2023-2024 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 childcare 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.**

   *****Full Day Care is from 8:30 am to 4:00 pm with extended care from 6:30 am to 8:30 am and from 4:00pm to 6:00pm. Half Day Care is from 7:00 am to 12:00 pm. Please contact our youth and family office for 4k care that may vary for half day.**

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 childcare 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 7:00 am to 12:00pm	$34/$39	$31/$36	☐ 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 8:30 am to 4:00 pm	$46/$51	$43/$48	**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**_____

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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: X _____

Today's Date: _____

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

Group Child Care & Outside of School Hours Centers — FFY 2024, rev. 6/23

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#)
X		***-**-___ ___ ___ ___ ☐ 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.*

CHILD AND ADULT CARE FOOD PROGRAM (CACFP) **For Group Child Care & Outside of School Hours Centers**
HOUSEHOLD LETTER (Non-Pricing Programs) **FFY 2024, Rev. 6/23**

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, Pregnant Women, Learnfare and Emergency Payments.

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, 2023 to June 30, 2024)

Household Size	Annual Income Level (at or below)
1	$ 26,973
2	$ 36,482
3	$ 45,991
4	$ 55,500
5	$ 65,009
6	$ 74,518
7	$ 84,027
8	$ 93,536
For each additional Household Member, add:	+$ 9,509

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.

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Signature of Agency Representative