

Office Use Only	
Date Application Received:	
Enrollment Start Date:	
Intake Specialist/Staff:	
Additional Information:	



DYCD Universal Participant Intake: Youth & Adult Application

Welcome to the Department of Youth and Community Development (DYCD)! DYCD is a New York City agency that funds programs for youth and families. These programs are operated by Community Based Organizations (CBOs). This form will allow you or your child to apply to a DYCD Comprehensive Afterschool System (COMPASS),

Beacon, or Cornerstone youth or adult program. Please complete this form fully and return to the CBO that operates the program. One application will be accepted per person per site. **Submission of an application does not guarantee enrollment in the program.** Further paperwork and information may be required to determine program eligibility. If accepted, program will be **at no cost** to the participant. The following application items are collected for informational and program planning purposes only: *Income, Gender, Race, Ethnicity, Language, Population Type, Household Information and Health Insurance Status.* Responses to these questions will not impact your eligibility to receive services and will not be shared outside of DYCD without the applicant's permission.

Part I: Applicant Information

For the purposes of this application, *applicant* refers to the person applying to receive services. Select one:

- I am completing this application for myself
- I am a parent or guardian completing this application for my child
- I am a relative/non-relative, completing this application on behalf of the applicant

Applicant's First Name:		Applicant's Last Name:		MI:
Applicant's Date of Birth (MM/DD/YEAR):				
Applicant's Gender (Select One):		Applicant's Race (Select all that Apply):		Applicant's Ethnicity (Select One):
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender Nonconforming		<input type="checkbox"/> American Indian and Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Native Hawaiian and Other Pacific Islander <input type="checkbox"/> White or Caucasian <input type="checkbox"/> Other		<input type="checkbox"/> Hispanic or Latino(a) <input type="checkbox"/> Not Hispanic or Latino(a)
Applicant's Primary Address (Number and Street):				Apt. Number:
City:				Zip Code:
<input type="checkbox"/> Applicant lives in a NYCHA Development (please provide name) _____				

Part II: Contact Information

Applicant's Contact Information

For youth without contact information, skip to the next section to provide parent/guardian contact information

Write down phone numbers for the applicant and circle the preferred method of contact:

- Home _____ Cell _____
 Work _____ Email _____ No Email

Parent/Guardian Information

This section is required for Applicants under 18

Parent/Guardian Name: _____

Write down all phone numbers and circle the best number to call in case of an emergency:

- Home _____ Cell _____
 Work _____ Email _____ No Email

Address: _____	City: _____	State: _____	Zip Code: _____
<input type="checkbox"/> Same as Participant			

Emergency Contact Information

At least one emergency contact must be identified

1	Emergency Contact #1 Name: _____	Relationship to Participant: _____		
	<input type="checkbox"/> Emergency contact is parent/guardian of participant			
	<p>Write down all phone numbers and circle the best number to call in case of an emergency:</p> <input type="checkbox"/> Home _____ <input type="checkbox"/> Cell _____ <input type="checkbox"/> Work _____ <input type="checkbox"/> Email _____ <input type="checkbox"/> No Email			
Address: _____		City: _____	State: _____	Zip Code: _____
<input type="checkbox"/> Same as Participant				
2	Emergency Contact #2 Name: _____	Relationship to Participant: _____		
	<input type="checkbox"/> Emergency contact is parent/guardian of participant			
	<p>Write down all phone numbers and circle the best number to call in case of an emergency:</p> <input type="checkbox"/> Home _____ <input type="checkbox"/> Cell _____ <input type="checkbox"/> Work _____ <input type="checkbox"/> Email _____ <input type="checkbox"/> No Email			
Address: _____		City: _____	State: _____	Zip Code: _____
<input type="checkbox"/> Same as Participant				



This section is for parents/guardians enrolling their children

Emergency contacts listed in Section II are authorized to pick up the child unless otherwise noted.

The following additional people are authorized to pick up my child:

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

The following people MAY NOT pick up my child:

Name: _____ Name: _____ Name: _____

Part III: Applicant's Education/Work Status

Applicant's Education Status (Select One):

- Full-Time Student*** Part-Time Student*** Not in School****

***If applicant is a *Part-Time Student* or *Full-Time Student*: **Select applicant's current grade (Select One):**

****If applicant is *Not in School*: **Select the last grade completed by the applicant (Select One):**

Elementary School: Pre-K K 1st 2nd 3rd 4th 5th

Middle School: 6th 7th 8th

High School: 9th 10th 11th 12th

Community College: 1st year 2nd Year 3rd year 4th Year 5th year 6th Year+

College/University: Freshman Sophomore Junior Senior

Other: High School Equivalence (HSE) Vocational/Trade School Foreign Degree

Applicant's Current Work Status (Select One):

- Employed Full-Time Employed Part-Time Retired
 Unemployed (Short-Term, 6 months or less) Unemployed (Long-term, more than 6 months) Unemployed (Not in labor force)
 Migrant Seasonal Farm Worker Not applicable (applicant is under 14 years of age)

Required for Full-Time Students

Student ID/ OSIS:

School Type:

- Public Charter Private Other _____

School Name:

School Address:

City:

Zip Code:

Part IV: Health Information

Applicant's Health Information

*Please answer the questions below and provide additional details in the space provided.
Many needs or health challenges can be accommodated and may not limit enrollment in the program.*

Does the applicant have any allergies? (food, medication, etc.)

No Yes _____

Does the applicant have asthma?

No Yes

Does the applicant have special health care needs?

No Yes _____

Does the applicant take medication for any condition or illness?

No Yes _____

Are there activities the applicant cannot participate in?

No Yes _____

Please provide any additional health information details:

N/A

Please list any accommodation(s) you are requesting for yourself/the applicant:

N/A

Applicant's Health Insurance Status

Does the applicant have health insurance? (Select One):

Yes No
 Decline to Answer

If yes, what kind of health insurance does the applicant have? (Check all that Apply):

Medicaid Medicare State Children's Health Insurance Program
 Employment-Based Direct-Purchase State Children's Health Insurance for Adults
 Military Health Care Decline to Answer

If you do not have health insurance, do you want to be contacted by someone else with information about signing up for public health insurance? (Select One):

Yes No Decline to Answer

If you would like to be contacted about signing up for public health insurance, what is your preferred method of contact? (Select One):

Email Phone US Mail Via provider
 Decline to Answer

Part V: Additional Applicant Information

How well does the applicant speak English?
(Select One):

- Fluent/Very well
- Well
- Not well
- Not well at all

Applicant's Primary Language (Select One):

- | | | |
|---|--|-----------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Albanian | <input type="checkbox"/> Arabic |
| <input type="checkbox"/> Bengali | <input type="checkbox"/> Chinese* | <input type="checkbox"/> French |
| <input type="checkbox"/> Fulani | <input type="checkbox"/> German | <input type="checkbox"/> Gujarati |
| <input type="checkbox"/> Haitian Creole | <input type="checkbox"/> Hebrew | <input type="checkbox"/> Hindi |
| <input type="checkbox"/> Hungarian | <input type="checkbox"/> Italian | <input type="checkbox"/> Japanese |
| <input type="checkbox"/> Korean | <input type="checkbox"/> Kru, Ibo, or Yoruba | <input type="checkbox"/> Mande |
| <input type="checkbox"/> Punjabi | <input type="checkbox"/> Persian | <input type="checkbox"/> Polish |
| <input type="checkbox"/> Portuguese | <input type="checkbox"/> Romanian | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Spanish | <input type="checkbox"/> Tagalog | <input type="checkbox"/> Turkish |
| <input type="checkbox"/> Urdu | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Yiddish |

Other: _____
**including Cantonese and Mandarin*

Other Languages Spoken by Applicant (Select all that Apply):

- | | | |
|---|--|-----------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Albanian | <input type="checkbox"/> Arabic |
| <input type="checkbox"/> Bengali | <input type="checkbox"/> Chinese* | <input type="checkbox"/> French |
| <input type="checkbox"/> Fulani | <input type="checkbox"/> German | <input type="checkbox"/> Gujarati |
| <input type="checkbox"/> Haitian Creole | <input type="checkbox"/> Hebrew | <input type="checkbox"/> Hindi |
| <input type="checkbox"/> Hungarian | <input type="checkbox"/> Italian | <input type="checkbox"/> Japanese |
| <input type="checkbox"/> Korean | <input type="checkbox"/> Kru, Ibo, or Yoruba | <input type="checkbox"/> Mande |
| <input type="checkbox"/> Punjabi | <input type="checkbox"/> Persian | <input type="checkbox"/> Polish |
| <input type="checkbox"/> Portuguese | <input type="checkbox"/> Romanian | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Spanish | <input type="checkbox"/> Tagalog | <input type="checkbox"/> Turkish |
| <input type="checkbox"/> Urdu | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Yiddish |

Other: _____
 Not applicable (only one language spoken by applicant)

**including Cantonese and Mandarin*

**Would the applicant like to receive information/
be contacted about registering to vote?***
(Select One):

- Yes No

**Applicant is eligible to vote in U.S. federal elections if:
1) You are a U.S. citizen;
2) You meet your state's residency requirements;
3) You are 18 years old. Some states allow 17-year-olds to
vote in primaries and/or register to vote if they will be 18
before the general election. Check your state's voter
registration age requirements.

Is the applicant any of the following:

- Parent/Legal Guardian? Yes No
 Offender/Justice Involved? Yes No
 Foster Care Participant? Yes No
 Runaway Youth? Yes No
 Veteran? Yes No
 Active Military Personnel? Yes No
 An Individual with a Disability? Yes No Decline to answer

**If the applicant is an individual with a
disability, please select disability type(s)**
(Select all that Apply):

- Cognitive impairment
- Hearing-related
- Learning disability
- Mental or Psychiatric
- Physical/Chronic Health Condition
- Physical/Mobility Impairment
- Vision-related
- Other: _____
- Decline to Answer

Part VI: Household Information

For all the next set of questions, **HOUSEHOLD** is defined as any individual or group of individuals (family or non-family members) who are living together as one economic unit. **INCOME** is defined as the total annual gross income of all family and non-family members 18+years old living within the household.

The applicant lives in a household that is headed by
(Select One):

- | | |
|--|--|
| <input type="checkbox"/> Single Parent - Female | <input type="checkbox"/> Two Adults – No Children |
| <input type="checkbox"/> Single Parent - Male | <input type="checkbox"/> Two Parent Household |
| <input type="checkbox"/> Single Person - No children | <input type="checkbox"/> Multigenerational Household |
| <input type="checkbox"/> Non-related adults with | <input type="checkbox"/> Other: _____ |

Applicant's Housing Type (Select One):

- | | | |
|--|-----------------------------------|--------------------------------|
| <input type="checkbox"/> Own | <input type="checkbox"/> Rent | <input type="checkbox"/> NYCHA |
| <input type="checkbox"/> Shelter | <input type="checkbox"/> Homeless | |
| <input type="checkbox"/> Other Permanent Housing | | |
| <input type="checkbox"/> Other: _____ | | |

Applicant's Household Size (Select One):

- | | | |
|-----------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> One | <input type="checkbox"/> Two | <input type="checkbox"/> Three |
| <input type="checkbox"/> Four | <input type="checkbox"/> Five | <input type="checkbox"/> Six |
| <input type="checkbox"/> Seven | <input type="checkbox"/> Eight | <input type="checkbox"/> Nine |
| <input type="checkbox"/> Ten | <input type="checkbox"/> Eleven | <input type="checkbox"/> Twelve |
| <input type="checkbox"/> Thirteen | <input type="checkbox"/> Fourteen | <input type="checkbox"/> Fifteen |
| <input type="checkbox"/> Sixteen | <input type="checkbox"/> Seventeen | <input type="checkbox"/> Eighteen |
| <input type="checkbox"/> Nineteen | <input type="checkbox"/> Twenty+ | |

Total Household Income in the last 12 Months (Select One):

- | | | |
|---|---|--|
| <input type="checkbox"/> \$0 | <input type="checkbox"/> \$1 to \$12,060 | <input type="checkbox"/> \$12,061 to \$16,240 |
| <input type="checkbox"/> \$16,241 to \$20,420 | <input type="checkbox"/> \$20,421 to \$24,600 | <input type="checkbox"/> \$24,601 to \$28,780 |
| <input type="checkbox"/> \$28,781 to \$32,960 | <input type="checkbox"/> \$32,961 to \$37,140 | <input type="checkbox"/> \$37,141 to \$41,320 |
| <input type="checkbox"/> \$41,321 to \$50,000 | <input type="checkbox"/> \$50,001 to \$60,000 | <input type="checkbox"/> \$60,001 to \$70,000 |
| <input type="checkbox"/> \$70,001 to \$80,000 | <input type="checkbox"/> \$80,001 to \$90,000 | <input type="checkbox"/> \$90,001 to \$100,000 |
| <input type="checkbox"/> \$100,000+ | <input type="checkbox"/> Decline to Answer | |

Sources of Applicant's Household Income (Select all that Apply):

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Employment Wages | <input type="checkbox"/> Affordable Care Act | <input type="checkbox"/> Alimony or other | |
| <input type="checkbox"/> Childcare Voucher | <input type="checkbox"/> Earned Income Tax | <input type="checkbox"/> Employment Tax Credit | <input type="checkbox"/> General Assistance |
| <input type="checkbox"/> Housing Choice Voucher | <input type="checkbox"/> HUD-VASH | <input type="checkbox"/> LIEHEAP | <input type="checkbox"/> Pension |
| <input type="checkbox"/> Permanent Supportive | <input type="checkbox"/> Private Disability | | |
| <input type="checkbox"/> Retirement Income | <input type="checkbox"/> Social Security
(SSDI) | <input type="checkbox"/> Supplemental Security | <input type="checkbox"/> Supplemental Nutrition
(SNAP) |
| <input type="checkbox"/> Temporary Assistance for | <input type="checkbox"/> Unemployment | <input type="checkbox"/> VA Non-Service
Pension | <input type="checkbox"/> VA Service-Connected |
| <input type="checkbox"/> WIC | <input type="checkbox"/> Worker's Compensation | <input type="checkbox"/> Other: _____ | |
| | | <input type="checkbox"/> Decline to Answer | |

Part VII: Consents and Signatures

Pick-up/Dismissal Information

This question must be answered for parents/guardians enrolling their children

My child has permission to travel home alone at dismissal:

Yes No

Consent to Participate

To the best of my knowledge the information above is true. I agree to its verification and understand that falsification may be grounds for termination of service. Information provided may be used by the City of New York to improve City services and access to those services, and to access additional funding.

If participant is 18 and over:

I acknowledge that I am 18 years of age or older and am authorized to give consent.

Yes No

Participant's Signature

Participant: Print Name

Date

If participant is under 18 years old:

Parent/Guardian's Signature

Parent/Guardian: Print Name

Date

Consent for Emergency Medical Treatment

If participant is 18 and over

I am enrolled as a participant in a DYCD-funded program. In the event of a medical emergency, I hereby give consent for necessary emergency medical treatment to be obtained on my behalf. I further authorize the emergency contact(s) listed to be contacted.

Yes, I give my permission No, I do not give permission

Participant's Signature

Participant: Print Name

Date

If participant is under 18 years old:

My child is enrolled as a participant in a DYCD-funded program. In the event of a medical emergency, I hereby give consent for necessary emergency medical treatment for my child to be obtained, with the understanding that I will be notified as soon as possible. I understand that every effort will be made to contact me, or, if I am unavailable, the emergency contact(s) listed, before and after medical care is provided.

Yes, I give my permission No, I do not give permission

Parent/Guardian's Signature

Parent/Guardian: Print Name

Date

Consent for Photography/Videotaping and Use of Original Work

As a participant enrolled in a DYCD-funded program, please be aware that from time to time DYCD and the City of New York, its contracted providers, authorized agents, third-party organizations with which it collaborates, or other government, representatives (collectively, "Authorized Parties") may be present during program activities and special events associated with program services, both at the usual program location and at off-site events. In some cases, they may photograph, videotape, interview or otherwise record participants and their families and friends in these programs. The resulting images, videos, and interviews may be used, with or without the participant's name, in printed and electronic media such as brochures, books, print and email newsletters, DVDs and videos, websites, social media and blogs (collectively, "Media").

I hereby authorize and permit the Authorized Parties, without compensation and without further approval, to photograph and/or record my and my child's image, name, likeness, and the sound of my and my child's voice during DYCD-funded program activities and special events, and I hereby consent to the resulting images, videos and interviews being used, without compensation and without further approval by the Authorized Parties solely for non-profit, non-commercial purposes in any and all Media.

Yes No

If, in the course of participating in DYCD-funded program activities and special events, any original work such as art, music, choreography, poetry, or prose (collectively, "Original Work") is created by me or my child, I hereby consent to such Original Work being used by the Authorized Parties, without compensation and without further approval, solely for non-profit, non-commercial purposes in any and all Media.

Yes No

If participant is 18 and over:

I acknowledge that I am 18 years of age or older and am authorized to give consent.

Yes No

Full Name of Participant	Participant's Signature	Date
--------------------------	-------------------------	------

If participant is under 18 years old:

Full Name of Participant	Parent/Guardian's Signature	Date
--------------------------	-----------------------------	------



Parent/Guardian Consent to Collect and Share Student Information

The Department of Youth and Community Development (DYCD) provides funding for this program as part of its mission to help you assist your child reach his or her full potential. Many of our programs are run by community based organizations. We work to make sure the services you and your children receive are of the highest quality. DYCD is requesting your permission to allow us to collect information we need on your child, their participation and the quality of the services provided.

What information from your child's student records is DYCD requesting?

We are requesting your permission for the NYC Department of Education (DOE) to share personally identifiable information from your child's student records with DYCD. The information we would like to collect consists of biographical and enrollment information (specifically consisting of your child's name, address, date of birth, student identification number, grade, school(s) attended and transfer, discharge, and graduation data about your child); data concerning your child's school attendance (including number of days attended and absences); and academic performance data (including your child's results on state and national exams, credits earned, grades, promotion and retention status, and fitnessgram score); and data related to any disciplinary actions taken against your child (including number and type of suspensions).

We are requesting to collect the information listed above about your child on a past, present and future (i.e., ongoing) basis.

We are also requesting your permission for DYCD to share information we collect on the enrollment form from you and/or your child with DOE staff. The information includes registration information, student's interests and challenges, type of program enrolled-in and frequency of participation. This information will be used to help the school and community organization work together to meet you and your child's needs.

Who will see my child's information and how will it be safeguarded?

The only people who will see your child's individual information are DYCD and DOE staff who manage the data systems and prepare research reports and program analyses. The limited number of DYCD staff identified to receive personal information is screened, and provided extensive training to follow strict guidelines on protecting the confidentiality of information that would personally identify you or your child. Personally identifiable information collected from student records will only be shared electronically between DOE and DYCD and will be secured and protected in the DYCD data base. Personally identifiable information will not be shared with any community based organizations or their staff members. We will not use your name or your child's name in any published report. While we request your consent, your responses to the below requests will not affect your child's participation in DYCD sponsored programs.

Please check Yes or No to each of the following statements:

I understand why DYCD is asking my permission to access the information listed above from my child's student records, and I give permission to DOE to share that information with DYCD on an ongoing basis.

Yes, I give my permission **No, I do not give my permission**

I understand why DYCD is asking my permission to share information about my child collected by DYCD with DOE staff and I give my permission to DYCD to share information with DOE on an ongoing basis.

Yes, I give my permission **No, I do not give my permission**

Student/Applicant Name: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Additional Parent/Guardian Name (optional): _____

Additional Parent/Guardian Signature (optional): _____

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician's Assistant or Nurse Practitioner

Name of Child:	Date of Birth:	Date of Examination:
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Immunizations required for entry into day care

Yes No

Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s).

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1 st Date	2 nd Date	3 rd Date	4 th Date	5 th Date
Polio (IPV or OPV)	1 st Date	2 nd Date	3 rd Date	4 th Date	
Haemophilus influenzae type B (Hib)	1 st Date	2 nd Date	3 rd Date	4 th Date OR 1 st Date (if given on or after 15 months of age)	
Pneumococcal Conjugate (PCV) for those born on or after 1/1/08)	1 st Date	2 nd Date	3 rd Date	4 th Date	
Hepatitis B	1 st Date	2 nd Date	3 rd Date		
Measles, Mumps and Rubella (MMR)	1 st Date	2 nd Date			
Varicella (also known as Chicken Pox)	1 st Date	2 nd Date			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:

Tests

Tuberculin Test Date: / / Mantoux Results: Positive Negative mm
 TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test. If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: / /
 Attach lead level statement
Lead Screening (Include All Dates and Results)

1 year / / Result: mcg/dL Venous Capillary
 2 years / / Result: mcg/dL Venous Capillary

Most recent date of lead screening (if different from above):
 / / Result: mcg/dL Venous Capillary

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely. If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

(Continued on reverse side)

CHILD IN CARE MEDICAL STATEMENT *(continued)*

Health Specifics

Comments

Are there allergies? (Specify) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is medication regularly taken? (Specify drug and condition) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is a special diet required? (Specify diet and condition) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any hearing, visual or dental conditions requiring special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any medical or developmental conditions requiring special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Summary of Physical Exam

Include special recommendations to child day care providers

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care.

Yes No

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

()
Phone

Date

Religious Exemptions

Public Health law Section 2164 allows a child to be religiously exempted from immunization. A written and signed statement from a parent, parents or guardian of the child stating that they object of the immunization of their child due to their sincere and genuine religious beliefs should be submitted to the day care owner, operator or administrator who shall determine whether the statement of religious belief is acceptable.

A Program of



Coalition for Hispanic Family Services

Building Strong Communities One Family at a Time

www.HispanicFamilyServicesNY.org

Rules & Regulations – Elementary School

Management at this community center strives to provide a safe and communal experience for all participants. Participants must abide by the following guidelines or they will run the risk of being suspended or expelled from the program, at the discretion of the Site Director and Director of Community Based Programs for CHFS.

**All situations will be reviewed on a case-by-case basis.*

1. I understand that attending the program's final performance is a mandatory event and failure to attend these events (3 times a school year) will put my child's spot at risk.
2. Parents must commit to meeting with community center management to address behavior challenges and/or behaviors which pose safety risks to themselves or others. Failure to attend meetings can result in a child's expulsion from the program.
3. It is the parent's responsibility to find suitable supervision, should your child be suspended.
4. Fighting, including play fighting, is strictly prohibited. Individuals who engage in fighting will be suspended or expelled.
5. Vandalism in and around the center is strictly prohibited and will lead to suspension or expulsion.
6. No weapons or anything that can be considered a weapon can be brought onto the property, and possession will lead to immediate expulsion.
7. No alcohol, cigarettes, or controlled substances are permitted on or around the premises, and possession will lead to immediate expulsion.
8. Theft is subject to criminal prosecution and expulsion.
9. Bullying, including cyberbullying, written, or verbal is not permitted and will result in suspension and/or expulsion.
10. Inappropriate touching or use of inappropriate language is not allowed. This includes, but is not limited to kissing, sitting on laps, holding, and hugging.
11. Nonconsensual photography, videotaping, or recording of participant activities is not permitted.
12. Cursing and profanity is not permitted at the center.
13. All participants must enter and exit the facility through the designated doors only.
14. Parent/Guardian must sign-in and sign-out daily on the master roster and check-in with the front desk staff.
15. Participants must wear clothing and shoes that are appropriate for trips and activity. Clothing should cover all undergarment areas: no crop tops, spaghetti straps, short shorts, underwear showing or clothing that reveals too much skin.
16. Eating is only allowed in designated areas.
17. Garbage and recyclables must be placed in their proper containers.
18. We are not responsible for lost or stolen items.

I acknowledge the Community Center Rules and Regulations and understand that failure to follow these rules will forfeit my ability to participate at the community center.

Participant Name: _____ **Participant Signature:** _____

(If under age 18) Parent Name: _____ **Parent Signature:** _____

Date: _____

A Program of



Coalition for Hispanic Family Services
Building Strong Communities One Family at a Time

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15. Participants must wear clothing and shoes that are appropriate for trips and activity. Clothing should cover all undergarment areas: no crop tops, spaghetti straps, short shorts, underwear showing or clothing that reveals too much skin.
16. Eating is only allowed in designated areas.
17. Garbage and recyclables must be placed in their proper containers.
18. We are not responsible for lost or stolen items.

I acknowledge the Community Center Rules and Regulations and understand that failure to follow these rules will forfeit my ability to participate at the community center.

Participant Name: _____ **Participant Signature:** _____

(If under age 18) Parent Name: _____ **Parent Signature:** _____

Date: _____

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME _____

Print the name of the child(ren) enrolled in this child care center

1. _____ 2. _____ 3. _____

DIRECTIONS

Complete SECTION A if anyone in your household

1. Participates in the Supplemental Nutrition Assistance Program (SNAP)
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPPIR) OR
4. Is a foster child

SECTION A

SNAP Case # _____

TANF # _____

FDPPIR # _____

Names of Foster Children _____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true. I understand that the center will get Federal funds based on the information I give.

Signature _____

Date _____

FOR SPONSOR USE ONLY	
CACFP Agreement # _____	
Total Number of Household Members _____ <small>(INCLUDING FOSTER CHILDREN, IF APPLICABLE)</small>	
Total Household Income \$ _____	
Free _____	Reduced _____
Paid _____	
Date of Determination _____	
Signature of Center Staff _____	

Complete SECTION B if no one in your household participates in SNAP, receives TANF, participates in FDPPIR or if none of the children enrolled in the child care center is a foster child.

SECTION B

List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received **last month** in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, child support, foster child's personal income and any other sources of income.

HOUSEHOLD MEMBER NAME	MONTHLY GROSS SALARY
1. _____	\$ _____
2. _____	\$ _____
3. _____	\$ _____
4. _____	\$ _____
5. _____	\$ _____
6. _____	\$ _____
7. _____	\$ _____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true and that all income is reported. I understand that the center will get Federal funds based on the information I give.

Signature _____

Print Name _____

LAST FOUR (4) DIGITS OF SOCIAL SECURITY NUMBER

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DATE _____

USDA is an equal opportunity provider and employer.

