U.S. Army
Child, Youth & School
Services

Registration Requirements
FOR
CYSS PROGRAMS

- Official shot records or medical records with a negative TB tine test at 12 months, between 4 and 6 years, and then again at 14.
- A current health assessment is due within 30 days of registration. The Health Assessment or Sports Physical is required by the first day of sports practice.
- Birth Certificate or any legal document which indicates child's birth date.
- Dual/Single Military are required to provide a copy of a Family Care Plan (DA Form 5305-R) within 30 days of registration.
- Two emergency designees other than parents or guardians of the child. You have 30 days to provide the third designee.
- Proof of total family income: last end of month LES and/or spouse pay stub for fee assessment.
- Parent or guardian must complete an orientation prior to child starting at any CYSS program

Questions should be directed to the Registration Office at the following numbers: AMR 833-5393 or Schofield Barracks at 655-5314

Hours of Operation:
AMR = 0800-1730: Walk-ins 0800-1200 and Appointments only from 1300-1600.

SCHOFIELD BARRACKS = 0730-1730: Walk-ins 0730-1100 and Appointments only from 1200-1600.

CHILD CARE CENTERS FY 2008 - 2009
INCOME ELIGIBILITY STATEMENT

CENTER NAME: _____

PART 1

Child's Name: _____

2nd Child : _____ _____ _____ _____ _____
Last First M.I. Birthdate Age

PART 2A–HOUSEHOLDS NOW GETTING FOOD STAMPS OR TANF BENEFITS (Complete this part and sign the statement in Part 3 – DO NOT complete Part 2C. Part 4 is optional.)

Food stamp case number: _____ TANF identification number: _____

PART 2B–FOSTER CHILD (Complete Part 2B and Part 3, DO NOT complete part 2C. Part 4 is optional.) Complete a separate Income Eligibility Statement for each foster child. If this is a foster child check here [ ] and fill in the child's Monthly Personal Use Income: $_____

PART 2C–ALL OTHER HOUSEHOLDS (If you did not complete Part 2A or 2B, complete Part 2C and Part 3. Part 4 is optional.)

NAMES	CURRENT INCOME/HOW OFTEN IT IS RECEIVED – WEEKLY, EVERY 2 WEEKS, TWICE A MONTH OR MONTHLY			
Names of All Household Members	Earnings from Work (Before Deductions) Job 1	Welfare, Child Support, Alimony	Payments from Pensions, Retirement, Social Security	Earnings from Job 2 or Any Other Income
1.	$ /	$ /	$ /	$ /
2.	$ /	$ /	$ /	$ /
3.	$ /	$ /	$ /	$ /
4.	$ /	$ /	$ /	$ /
5.	$ /	$ /	$ /	$ /
6.	$ /	$ /	$ /	$ /

Zero Income: You must explain how your living expenses are being met. Temporary Approval is for 45 calendar days; the household must reapply within the 45 days.

PART 3–SIGNATURE (An adult household member must sign the statement before it can be approved.)

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that the food stamp or TANF number is correct or that all income is reported. I understand that this information is being given for the receipt of Federal funds; that institution officials may verify the information on the statement and the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

_____ ___-___-____ _____
Signature of Adult Social Security Number Printed Name of Adult

_____ _____ _____ _____ _____
Date Signed Home Telephone Work Telephone Home Address Zip Code

PART 4–RACIAL/ETHNIC IDENTITY (You are not required to answer this question.)

Mark one or more of the racial identities that best identifies you:

( ) Black or African American ( ) American Indian or Alaska Native ( ) Asian ( ) Native Hawaiian or other Pacific Islander ( ) White

Please mark one of the following ethnic identities: ( ) Hispanic or Latino ( ) Not Hispanic or Latino

Privacy Statement-Social Security Number Section 9 of the National School Lunch Act requires that, unless the participant's food stamp or TANF number is provided, you must include the social security number of the household member signing the statement or an indication that the household member signing the statement does not possess a social security number. Provision of a social security number is not mandatory, but if a social security number is not provided or an indication is not made that the adult household member signing the statement does not have one, the statement cannot be approved. The social security number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the statement. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a food stamp or TANF office to determine current certification for receipt of food stamps or TANF benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

The Child and Adult Care Food Program is an equal opportunity program. If you believe that you or anyone has been discriminated against because of race, color, age, national origin, sex or disability, write immediately to: USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 14th and Independence Avenue, SW, Washington, DC 20250-9410 or call (800) 795-3272 (voice) and (202) 720- 6382 (TDD).

For Sponsor Use Only: Food stamp/TANF household categorically eligible for program benefits: ( ) Yes ( ) No

ANNUAL INCOME CONVERSION: MONTHLY X 12, TWICE A MONTH X 24, EVERY 2 WEEKS X 26, WEEKLY X 52

Total Family Income: _____ Family Size: _____

Please Indicate eligibility classification with an (x) or (√) ( ) Free ( ) Reduced Price ( ) Above Scale

Determining Official: _____ Signature: _____ Date: _____

For Child Care Center Program use only

Revised 7/08

Child and Adult Care Food Program
INCOME ELIGIBILITY STATEMENT INSTRUCTIONS
Child Care Center Programs

Please complete the Child and Adult Care Food Program Income Eligibility Statement using the instructions below. Sign the statement and return it to the Center. Call the center if you need help: #

PART 1 - PARTICIPANT'S INFORMATION: (Complete This Part.)
(1) Print the name or names, birthdate(s), and age(s) of your own child(ren) enrolled in the center.

PART 2A - HOUSEHOLDS GETTING FOOD STAMPS OR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) BENEFITS (Complete Part 2 and Part 3. Part 4 is optional.)

(1) List your current food stamp case number or your TANF identification number for the participant. Do not complete Part 2C.
(2) An adult household member must sign **and provide other requested information in PART 3.**

PART 2B - FOSTER CHILD: (Complete Part2A and Part 3 for each Foster Child Living in Your Home and Enrolled for Care. Part 4 is optional.) Complete a separate Income Eligibility Statement for each foster child:_____

PART 2C – ALL OTHER HOUSEHOLDS (Complete This Part and Part 3. Part 4 is optional)

(1) Write the names of everyone in your household.
(2) Write the amount of income including COLA (the amount before taxes or anything else is taken out), how often income was received (i.e., weekly, every two weeks, twice a month, or monthly) last month for each household member, and where it came from, such as earnings, welfare, pensions, and other income (refer to examples below for types of income to report). If any amount last month was more or less than usual, write that person's usual income.
(3) You, the provider, or another adult household member must sign this income eligibility statement **and provide other requested information in PART 3.**
(4) ZERO INCOME – If the primary earner expects to return to work in 2 weeks, the temporary approval may be for a shorter time than 30 days. If the primary earner has lost his/her job and has no prospects for a new one, the household must reapply for temporary approval every 45 days with a written explanation of how living expenses are being met.

PART 3 –SIGNATURE AND SOCIAL SECURITY NUMBER: (All Households Complete This Part.)

(1) All income eligibility statements must have the signature of an adult household member;
(2) The adult household member who signs the statement must include his/her social security number. If he/she does not have a social security number, write "none" or something else to show that he/she does not have a social security number. If you listed a food stamp or TANF number, a social security number is not needed.

PART 4 – RACIAL/ETHNIC IDENTITY (Completion of part 4 is optional.)
You are not required to answer this question to get meal benefits. However, this information will help ensure that everyone is treated fairly.

INCOME TO REPORT

EARNINGS FROM EMPLOYMENT
Wages/salaries/tips (include COLA)
Strike benefits
Unemployment compensation
Workers' compensation
Net income from self-owned business or farm

WELFARE/CHILD SUPPORT/ALIMONY
Public assistance payments
Welfare payments
Alimony/child support payments

FOSTER CHILD'S INCOME
ONLY funds from welfare agency identified by category for personal use of child (clothing, school fees, etc.), funds from child's family for personal use and earnings from other than occasional or part-time employment. DO NOT COUNT funds from welfare agency for shelter, care, etc.

PENSION/RETIREMENT/SOCIAL SECURITY
Pension
Supplemental security income
Retirement income
Veteran's payment
Social security

MILITARY HOUSEHOLDS
All cash income, including COLA, military housing/ uniform allowances, does not include "in- kind" benefits NOT paid in cash (base housing, clothing, food, medical care, etc.).
Family Subsistence
Supplemental Allowance

OTHER INCOME
Disability benefits
Cash withdrawn from savings
Interest/dividends
Income from estates/trusts/investments
Regular contributions from persons not living in the household
Net royalties/annuities/net rental income
Any other income

For Child Care Center Program use only

Revised 7/08

CHILD AND YOUTH SERVICES HEALTH ASSESSMENT / SPORTS PHYSICAL

DATA REQUIRED BY THE PRIVACY ACT OF 1994

PRINCIPAL PURPOSE: Information is used by DA personnel to: (1) verify child health status of immunization per admission requirements; (2) note special program considerations or restriction on child participation; (3) execute emergency medical procedure for chronic illnesses/conditions; (4) refer child for enrollment in Exceptional Family Member Program; (5) certify physically fit to participate in sports. **ROUTINE USES:** No information is disclosed outside DOD. **DISCLOSURE:** Information is voluntary; however, if information is not provided, individuals may not be able to participate in community activities.

INSTRUCTIONS: Health Assessment complete sections A & C; Sports Physicals complete sections A, B & C.

PART A

Name of Sponsor	Home Telephone Cell Telephone	Duty/Work Telephone
Sponsor Unit / Work Address	Sponsor SSN	Spouse's Work Telephone

CHILD HEALTH INFORMATION

Name of Child	Birth Date	Sex ☐ Male ☐ Female

Does your child have ongoing medical concerns?
(If Yes, explain circumstances and current status)

☐ Yes ☐ No

Is your child enrolled in Exceptional Family Member Program?
(If Yes, explain)

☐ Yes ☐ No

MEDICAL HISTORY

	YES	NO		YES	NO
1. Any hospitalization or operations			14. Heat stroke or exhaustion		
2. Allergies to medicine, insect bites or food			15. Broken bones or sprains		
3. Speech or development delays			16. Joint injuries (Ankle/Knee/Wrist)		
4. Vision Problems (Glasses / Contacts)			17. Required restricted physical activity		
5. Ear or hearing problems			18. Diabetes		
6. Seizures or Convulsions			19. Cancer		
7. Dizziness or fainting with exercise			20. Dental or orthodontic braces		
8. Headaches			21. Learning problems		
9. Head injury or loss of consciousness			22. Sleep problems		
10. Neck or back injury			23. Behavioral problems		
11. Asthma or difficulty breathing			24. ADD / ADHD		
12. Heart or blood pressure problems			25. Other problems (list below)		
13. Chest pain with exercise					

If you answer yes to any of the above, please explain:

Ongoing Medications

Name	Dosage	Frequency

Allergies – All Types (Foods, Medicines and Insect Bites)

Type	Reaction

PART B: SPORTS PHYSICAL

Medical Staff Assessment (Completed by licensed independent practitioner)

Age YRS MOS	Height cm. (%ile)	Weight kgs. (%ile)
BP: / P:	Visual Acuity Right / Left	Tested with / without glasses

	NORMAL	ABNORMAL	N / A	COMMENTS
1. Eyes				
2. Ears, Nose & Throat				
3. Hearing				
4. Mouth & Teeth				
5. Neck (Soft tissues)				
6. Cardiovascular				
7. Chest & Lungs				
8. Abdomen				
9. Genitalia – Hernia				
10. Skin & Lymphatics				
11. Spine – Scoliosis				
12. Extremities				
13. Neurological				
14. Wears braces / plates				

Based on this HX and PX exam, the following abnormalities were found and may need treatment:

Immunizations are current and up to date: ☐ Yes ☐ No

PARTICIPATION RECOMMENDATIONS

☐ All sports _____Yes _____ No ☐ Normal physical activity to including PE

☐ PA Additional comments: ☐ Restrictions:

Sports Physical is valid for 1 year from date indicated below

PART C

Special Medical Considerations: Describe any special program needs, considerations or restrictions which the child requires in order to participate in CYS programs (to include Sports).

Child / Youth is able to participate in normal CYS programs? ☐ Yes ☐ No

Date	Licensed Health Care Professional Stamp	Licensed Health Care Professional Signature

Date	Type or print name of Parent or Guardian	Signature of Parent or Guardian

Health Assessment Re-Certification

Date	Health Status Changed	Signature of Parent or Guardian
	☐ Yes ☐ No	
Date	Health Status Changed	Signature of Parent or Guardian
	☐ Yes ☐ No	

APPLICATION FOR DEPARTMENT OF DEFENSE CHILD CARE FEES

PRIVACY ACT STATEMENT

AUTHORITY: Public Law 101-189, Section 1504; E.O. 9397.

PRINCIPAL PURPOSE(S): To collect total family income data to determine child care fees.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary; however, failure to furnish information will result in placement in the highest fee range.

SECTION I - DEPENDENT CHILDREN

To determine child care fees for your child(ren), or any child(ren) you legally claim as your dependent(s), you must complete, sign, and return this form to the director of the program you are applying for. Fees will be determined based on your total family income as defined below. If you do not wish to disclose your total family income, your rate will be set automatically at the highest fee level.

1. NAME OF EACH CHILD *(LAST, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. AGE	4. CARE REQUESTED
a.			
b.			
c.			
d.			
e.			

SECTION II - ANNUAL FAMILY INCOME *(To be completed by sponsor. Include all military and civilian earned income for sponsor and spouse.)*

Enter your annual income data as requested; e.g., multiply the most recent monthly income by 12 or if paid on a biweekly income, enter the most recent biweekly income and multiply by 26. For purpose of determining child care fees in DoD Child Care program, total family income is defined as all earned income including wages, salaries, tips, long-term disability benefits, combat pay and voluntary salary deferrals. Include all earned income such as wages, salaries, tips, long-term disability benefits, voluntary salary deferrals, retirement or other pension income, etc., before deductions for taxes, social security, etc. Include quarters subsistence and other allowances appropriate for the rank and status of military or civilian personnel whether received in cash or in kind. For dual military living in government quarters include BAH-II of senior member only. Include anything else of value, even if not taxable, that was received for providing services. DO NOT INCLUDE cost of living allowance (COLA) received in high cost areas, alimony and child support, temporary duty allowances or reimbursements for educational expenses.

5. SPONSOR

a. NAME *(LAST, First, Middle Initial)*	b. SSN	c. YEARS OF MILITARY/CIVIL SERVICE

d. INCOME

(1) BASE PAY *(Most recent leave and earnings statement)*	(2) BASIC ALLOWANCE FOR HOUSING *(Or in-kind equivalent) (Annual chart of minimum BAH-II)*	(3) BASIC SUBSISTENCE ALLOWANCE *(Or in-kind equivalent)*	(4) OTHER EARNED INCOME AS DESCRIBED ABOVE

6. SPOUSE

a. NAME *(LAST, First, Middle Initial)*	b. SSN	c. YEARS OF MILITARY/CIVIL SERVICE

d. INCOME

7. OTHER EARNED INCOME AS DESCRIBED ABOVE	8. TOTAL INCOME FOR SPONSOR, SPOUSE, AND OTHER

SECTION III - CERTIFICATION OF SPONSOR (*Required for Category I - IV. Please read the following statement carefully before signing.)*

I certify that all of the above information is true and correct and that all family income of the spouse and sponsor is reported. I understand that this information is being given in order to determine child care fees to be paid and that Federal funds are used to subsidize the cost of child care. I also understand that the installation commander may verify the information on the application; and that deliberate misrepresenta- tion of this information may subject me to prosecution under applicable State and Federal laws. See 18 U.S.C. Section 1001.

9. SIGNATURE OF SPONSOR*	10. SIGNATURE OF SPOUSE	11. DATE SIGNED *(YYYYMMDD)*

**If signature is missing, the fees will automatically be placed at the highest level.*

12. TELEPHONE NUMBERS *(Include Area Code)*		13. HOME ADDRESS *(List apartment number and 9-digit ZIP Code)*
a. HOME	b. WORK	
(1) SPONSOR		
(2) SPOUSE		

SECTION IV - FOR CHILD DEVELOPMENT CENTER USE ONLY

14. CATEGORY OF APPROVAL	15. AUTHORIZED FEES
16. DATE OF APPROVAL *(YYYYMMDD)*	17. NAME OF CHILD DEVELOPMENT PROGRAM OFFICIAL

ARMY CHILD AND YOUTH SERVICES HEALTH SCREENING TOOL

For use of this form, see AR 608-75; the proponent agency is OACSIM.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 3013, Secretary of the Army; 29 U.S.C. 794, Nondiscrimination Under Federal Grants and Programs; DoDD 1342.17 Family Policy; AR 608-75, Exceptional Family Member Program; AR 608-10, Child Development Services; and E.O. 9397 (SSN).

PRINCIPAL PURPOSE: Information will be used to assist Army activities in their responsibilities in overall execution of the Army's Exceptional Family Member Program (EFMP) and the Army Child and Youth Services Program.

ROUTINE USES: The DoD "Blanket Routine Uses" that appear at the beginning of the Army's compilation of systems of records apply to this system.

DISCLOSURE: Disclosure of requested information is voluntary; however, if information is not provided individual may not be able to participate in Army Child and Youth Services Program.

Part A - General Information

1. Child's Name	2. Date of birth (YYYYMMDD)
3. Family member prefix	
4. Type of placement requested	5. Date (YYYYMMDD)
6. Sponsor name	7. SSN (last four digits)
8. Spouse name	
9. Home phone	10. Duty phone / 11. Cell phone

Part B - Identification of Child/Youth Condition/Restrictions

Child has any of the following conditions/restrictions: (Check yes or no)

1. Allergies ☐ No ☐ Yes (explain)

   a. Life threatening reaction ☐ No ☐ Yes (explain)

   b. Epi-pen required ☐ No ☐ Yes

   c. Other allergic reations (hives, rash, diarrhea) ☐ No ☐ Yes

2. Asthma reactive airway disease ☐ No ☐ Yes (explain)

   a. Triggers exist for child's asthma attacks (stress, environmental, exercise) ☐ No ☐ Yes (explain)

   b. Child routinely (greater than 10 days per month/four months per year) uses inhaled anti-inflammatory agents and/or bronchodilators ☐ No ☐ Yes (explain)

   c. Child has taken steroids during the past year (prednisone, prednisolone) ☐ No ☐ Yes (indicate number of days in past year)

d. Child has experienced unconsciousness or seizures associated with asthma attacks
☐ No ☐ Yes (explain)

e. Child required an urgent visit to emergency room or clinic for acute asthma within the last 12 months
☐ No ☐ Yes (indicate number of visits in the past year)

f. Child has been hospitalized for asthma related condition in the past six months
☐ No ☐ Yes (explain)

3. Attention Deficit Disorder (ADD)
☐ No ☐ Yes

a. ADD with hyperactivity
☐ No ☐ Yes

b. Is not well controlled with medication
☐ No ☐ Yes (not well controlled)

c. Behavioral/conduct concerns
☐ No ☐ Yes (explain)

4. Autism
☐ No ☐ Yes

5. Behavioral/conduct concerns (for example, oppositional defiant disorder, anxiety disorder, school phobias)
☐ No ☐ Yes (explain)

6. Blindness/visual problems
☐ No ☐ Yes (explain)

7. Diabetes
☐ No ☐ Yes (explain)

8. Emotional problems that require care by a psychiatrist, psychologist or social worker
☐ No ☐ Yes (explain)

9. Epilepsy
☐ No ☐ Yes (explain)

10. Hearing problems
☐ No ☐ Yes (explain)

11. Heart problems
☐ No ☐ Yes (explain)

12. Kidney problems
☐ No ☐ Yes (explain)

13. Speech/language delay
☐ No ☐ Yes (explain)

14. Physical disability
☐ No ☐ Yes (explain)

15. Dietary restrictions
☐ No ☐ Yes (explain)

16. Assistance with activities of daily living

☐ No ☐ Yes (explain)

17. Other conditions

☐ No ☐ Yes (specify and explain)

Part C - Medications

Child is on medications on a regular basis

☐ No ☐ Yes (If yes, please list medications and indicate which require administration during child care hours.)

Part D - Early Intervention and Special Education

Child has an Individualized Family Service Plan (IFSP), Individualized Education Plan (IEP) or 504 plan

☐ No ☐ Yes

Part E - Exceptional Family Member Program (EFMP) Enrollment

Child is enrolled in the EFMP

☐ No ☐ Yes (specify for what condition)

I authorize _____ (name of Medical Treatment Facility or physician's practice) to release any medical information regarding my child _____ (name of child) to the _____ (name of installation) Child Youth Services (CYS)/Special Needs Accommodation Process (SNAP) personnel and their staff that is necessary to conduct SNAP review. This authorization will remain in effect for one year. I understand I may revoke this consent in writing at any time before expiration, but any action taken by the CYS/SNAP in reliance on this authorization prior to revocation is valid and will remain in effect.

I understand that information disclosed pursuant to this authorization is For Official Use Only (FOUO) and may be subject to redisclosure. I understand that information redisclosed is no longer protected by DoD 6025.18-R; however, confidentiality of this information will remain protected by the Privacy Act of 1974, 5 U.S.C. section 552a.

The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.

_____ _____

Signature of Parent or Personal Representative of Child Date (YYYYMMDD)

PROGRAM REGISTRATION FORM
Child & Youth Services

Original Reg. Date:

SPONSOR: _____ Cell Ph # _____
Grade Last First

Home Address: _____
(include zip code)

Hm Phone #: _____

Dual Military Y/ N *(circle one)* On Post/ Off Post *(circle one)*

Duty/Work Address: _____
(include zip code)

Wk Phone #: _____

AKO or E-mail Address _____

Total Family Size: _____ Status: Active / Retired / DA Civilian / Civilian *(circle one)*

SPOUSE: _____ Cell Phone # _____
Grade Last First

Duty/ Work or College Address _____
(include zip code)

Wk Phone #: _____

AKO or E-Mail Address _____

Status: Active / Retired / DA Civilian / Civilian *(circle one)*

CHILD: _____ _____
Last First M.I.

DOB: _____ Gender: M / F *(circle one)* School: _____

Medical Concerns: _____

Allergies: _____

CHILD: _____ _____
Last First M.I.

DOB: _____ Gender: M / F *(circle one)* School: _____

Medical Concerns: _____

Allergies: _____

CHILD: _____ _____
Last First M.I.

DOB: _____ Gender: M / F *(circle one)* School: _____

Medical Concerns: _____

Allergies: _____

CHILD: _____ _____
Last First M.I.

DOB: _____ Gender: M / F *(circle one)* School: _____

Medical Concerns: _____

Allergies: _____

EMERGENCY NOTIFICATION DESIGNEES(S):

Name (1): _____ Home Phone: _____

Child Release Designee: Yes / No *(circle one)* Duty/Work Phone: _____

Name (2): _____ Home Phone: _____

Child Release Designee: Yes / No *(circle one)* Duty/Work Phone: _____

Name (3): _____ Home Phone: _____

Child Release Designee: Yes / No *(circle one)* Duty/Work Phone: _____