DEPARTMENT OF AIR FORCE

CHILD AND YOUTH PROGRAMS

New Child Form

State Date: _____ Room #: _____

Orientation Date and Time: _____

Child's Name: _____

Child's DOB: _____

Sponsor's Name: _____

Sponsor's Rank: _____ Branch of Service: _____

Sponsor's Unit: _____ Sponsor's Phone #: _____

Spouse's Name: _____

Spouse's Employment: _____

Spouse's Phone #: _____

Allergies and Special needs (IAT paperwork will be required prior to start of care):

_____

Please sign:

I have received the Parent Handbook and Disciplinary Policy

_____ _____

(Print Name) (Signature)

CYP Personnel Complete:

- ☐ Household created in CYMS
- ☐ Issue child pass in CYMS
- ☐ Child placed in classroom
- ☐ Amount due for 1st day
- ☐ Shots entered in CYMS
- ☐ Cross check 1181 with CYMS
- ☐ IAT completed (if needed)
- ☐ Credit card input into Orbital/shredded
- ☐ Inform classroom of new child
- ☐ Folder created
- ☐ TFI calculation completed
- ☐ 2652 completed
- ☐ Fee adjusted in CYMS
- ☐ Key fob issued
- ☐ USDA form completed
- ☐ Allergy list updated
- ☐ Complete offer on MCC

Updated 10 June 2021

JBER CHILD AND YOUTH PROGRAMS 2021 HOLIDAY & TRAINING SCHEDULE

HOLIDAY/EVENT	DATE	JBER CYP FACILITIES	SIGN UP BEGIN/ END DATE	LIMITED CARE FACILITY
PACAF Family Day	31-Dec-20	CLOSED	30-Nov-20 thru 11-Dec-20	FCC Providers
New Year's Day	1-Jan-21	CLOSED		
PACAF Family Day	15-Jan-21	Limited Child Care	21-Dec-20 Thru 4-Jan-21	Denali CDC/Both SAC
Martin Luther King Day	18-Jan-21	CLOSED		
PACAF Family Day	12-Feb-21	CLOSED/CYP Training Day	19-Jan - 29-Jan	FCC Providers
President's Day	15-Feb-21	CLOSED		
PACAF Family Day	28-May-21	Limited Child Care	3-May - 14-May	Katmai CDC/Illa SAC
Memorial Day	31-May-21	CLOSED		
PACAF Family Day	2-Jul-21	Limited Child Care	7-Jun - 18-Jun	Sitka CDC/Ketchikan SAC
Independence Day (Observed)	5-Jul-21	CLOSED		
PACAF Family Day	3-Sep-21	Limited Child Care	9-Aug - 20-Aug	Talkeetna CDC/Both SAC
Labor Day	6-Sep-21	CLOSED		
PACAF Family Day	8-Oct-21	CLOSED/CYP Training Day	7-Sep - 18-Sep	FCC Providers
Columbus Day	11-Oct-21	CLOSED		
Veteran's Day	11-Nov-21	CLOSED		
PACAF Family Day	12-Nov-21	Limited Child Care	12-Oct - 23-Oct	Denali CDC/Both SAC
Thanksgiving Day	25-Nov-21	CLOSED		
PACAF Family Day	26-Nov-21	CLOSED	1-Nov - 10-Nov	FCC Providers
PACAF Family Day	23-Dec-21	CLOSED	29-Nov - 10-Dec	FCC Providers
Christmas Day (Observed)	24-Dec-21	CLOSED		

DEPARTMENT OF THE AIR FORCE
HEADQUARTERS, 673D AIR BASE WING
JOINT BASE ELMENDORF-RICHARDSON, ALASKA

16 Sep 2019

MEMORANDUM FOR CHILD AND YOUTH PROGRAMS

FROM: 673 FSS/FSY

SUBJECT: Updated Mission Essential Closure updates

1. In the event the 673d Air Base Wing (ABW) Commander directs only mission essential personnel report to Joint Base Elmendorf-Richardson (JBER), all Child and Youth Programs will be closed, including Child Development Centers (CDC) and School Age Centers (SAC). Civilian staff that work in these facilities are not considered mission essential. If the announcement happens after children have arrived for care, no additional children will be accepted into care and parents will be notified to pick up their children within 2 hours of notification.

2. In the event the 673d ABW Commander directs delayed reporting for JBER personnel, CYP will open 1 hour before the scheduled reporting time. Additionally, CYP will close within 2 hours of announcement of early release of JBER personnel.

3. Family Child Care providers will have limited spaces available for those who are in mission essential positions on JBER and need care to report for work. The mission essential forms and additional information can be found by calling Ms. Connie Nicholson at 552-3995. Care must be arranged in advance of base closures.

4. If you have any questions, please feel free to direct them to your facility director.

FOTHERGILL.HEATHER.S.1027345014
Digitally signed by FOTHERGILL.HEATHER.S.1027345014
Date: 2019.09.17 10:12:12 -08'00'

HEATHER S FOTHERGILL
Chief, Child and Youth Programs

Form A *(to be completed by parent/guardian)*

DEPARTMENT OF AIR FORCE
CYP
CHILD AND YOUTH PROGRAMS

Child and Youth Program
Joint Base Elmendorf-Richardson
Inclusion Action Plan

PART A. To be completed by the parents/guardians.

Child's name: _____ DOB: _____ Date: _____

Circle one: Hourly Care - Full Time Care - Part Day Preschool - Before and After School – Youth-Sports

Sponsor's name: _____ Email_____

Spouses' name: _____Email_____

Home phone: _____ Cell phone: _____

Does your child have allergies, developmental delays, behavioral concerns or any other medical condition?

Check a box. ☐ **Yes** (Proceed to Part B). ☐ **No** (DO NOT PROCEED) _____
(Parent/Guardian signature)

PART B. Parents/guardians, check the appropriate box or boxes, get the appropriate paperwork and have it signed by a physician.

CHRONIC CONDITIONS		
Form D Required ☐ Respiratory (Asthma) **Form E Required** ☐ Seizure Disorder **Form F Required** ☐ Diabetes	**Form B Required** ☐ Blindness/Vision Condition ☐ Heart Condition ☐ Kidney Condition ☐ Deafness/Hearing Condition ☐ Developmental Delay ☐ Cerebral Palsy ☐ Atopic Disease	**Form B Required** ☐ Speech Concern ☐ Autism Spectrum ☐ ADHD ADD ☐ Anxiety ☐ Behavioral Concerns ☐ Other _____ _____ _____
Provide details for checked items (month and year with current status) :		

DIETARY AND FEEDING CONCERNS		
Form C Required		
☐ Food Allergies ☐ Feeding Concerns	☐ Special Diet Statement Provided ☐ Swallowing Difficulty/Aspiration risk	☐ Other _____ _____

Provides details for checked items: _____

_____

_____

Form A *(to be completed by parent/guardian)*

Does your child/youth receive special services/therapies? □ **Yes** □ **No** Please specify:

_____

Is your child/youth enrolled in the EFMP? □ **Yes** □ **No** Please specify

_____

I acknowledge the information about my child will be shared with the Inclusion Action Team, Child and Youth Program personnel, and/or medical professionals in order to receive individualized recommendation for accommodations and support.

_____ _____

Parent's signature Date

DEPARTMENT OF AIR FORCE

CHILD AND YOUTH PROGRAMS

Credit Card Recurring Payment Authorization Form

Schedule your payments to be automatically charged to your credit card. Just complete and sign this form to get started.

Here's How Recurring Payments Work:

You authorize regularly scheduled charges to your Visa or MasterCard. You will be charged each billing period for the total amount due for that period. A charge will appear on your credit card statement. You agree that no prior-notification will be provided if the total payment is under the amount authorized below. If your bill is more than that amount, or the payment date changes, you will receive notice from us at least 10 days prior to the payment being collected.

Please complete the information below:

I _____ authorize _____ to charge my credit card on:
(Full Name) (Facility Name)

☐ The **first** of each month for my payment of my _____ in the amount of $_____.

☐ The 2nd and the 16th of each month for payment of my_____ in the amount of $_____.

☐ The **first** Monday of each week for payment of my _____ in the amount of $_____. (Youth ONLY)

I understand that I will only receive advance notice of the charge if it exceeds an amount different than authorized

Billing Address _____ Phone # _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX

Cardholder Name _____

CC Number _____

Expiration Date _____

SIGNATURE_____ DATE_____

I authorize the above named business to charge the credit card indicated in this authorization form according to the forms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing if any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

APPLICATION FOR DEPARTMENT OF DEFENSE CHILD CARE FEES

(Read Instructions on back before completing form.)

OMB No. 0704-0515
OMB approval expires 20231031

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 3013, Secretary of the Army; 10 U.S.C. 5013, Secretary of the Navy; 10 U.S.C. 5041, Headquarters, Marine Corps; 10 U.S.C. 8013, Secretary of the Air Force; DoD Instruction 6060.02, Child Development Programs; Army Regulation 608-10, Child Development Services; OPNAV Instruction 1700.9E series, Child and Youth Programs; Marine Corps Order P1710.30E, Children, Youth, and Teen Program (CYTP); Air Force Instruction 34-144, Child and Youth Programs.

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

ROUTINE USE(S): Department of the Army records may be disclosed to civilian health and welfare departments/agencies in emergencies. Department of the Navy records may be disclosed to local, state and Federal officials involved in child care services, if required, in the performance of their official duties relating to child abuse reporting and investigations. Department of the Air Force records may be disclosed to civilian health and welfare departments/agencies in emergency situations.
Additional Routine Uses can be found in the SORNS: Department of the Army: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570083/a0698a-cfsc/; Department of the Navy: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570426/nm01754-3/, Department of the Air Force: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/569755/f034-af-svo-c/.

DISCLOSURE: Required. Failure to provide the required information will delay the processing and approval of child care services.

SECTION I - DEPENDENT CHILDREN

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

SECTION II - ANNUAL FAMILY INCOME

5. SPONSOR

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

c. INCOME

(1) Income Data	(2) Basic Allowance for Housing (BAH)	(3) Basic Subsistence Allowance	(4) Other Earned Income	(5) Total Income - Sponsor (To be completed by Program Staff)

6. SPOUSE OR OTHER ADULT LIVING IN THE HOME

a. NAME *(Last, First, Middle Initial)*	b. INCOME

7. OTHER INCOME EARNED	8. TOTAL INCOME *(Include income from Blocks 5, 6, and 7. To be completed by Program Staff.)*

SECTION III - CERTIFICATION OF SPONSOR/DESIGNEE

(Required for all categories. 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 misrepresentation 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)*

SECTION IV - FOR CHILD DEVELOPMENT PROGRAM USE ONLY

12. PRIORITY SYSTEM ELIGIBILITY	13. CATEGORY OF APPROVAL	14. AUTHORIZED FEES	15. DATE OF APPROVAL *(YYYYMMDD)*	16. NAME OF CHILD DEVELOPMENT PROGRAM OFFICIAL

DEPARTMENT OF AIR FORCE

CHILD AND YOUTH PROGRAMS

Child and Youth Program
Photograph/Videotape Release

I ☐ do / ☐ do not (select one) grant permission for the Child and Youth to use my child's image in the following manners:

- Training purposes
- Classroom activities
- Memory books
- Program displays/advertisements

All of which may be seen/distributed throughout the Child and Youth Programs.

I ☐ do / ☐ do not (select one) grant permission for the Child and Youth to use my child's image in the following manners:

- JBER Life print publication
- Website content
- Print and digital advertisements
- Social media platforms.

All of which may be seen/ distributed throughout Joint Base Elmendorf-Richardson.

_____ _____

Child's Name (print) Parent's Name (print)

_____ _____

Parent Signature Date

Dear Parents:

Your day care facility participates in the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). CACFP needs verification of enrollment and income information for each participant in this facility.

Please complete the **Child Enrollment and Confidential Income Statement** included for all children in your household that are enrolled at this facility. The information should be completed by the parent/guardian. Please use the guides to complete and sign and date where noted.

Providing quality care at rates that families can afford is a growing challenge and requires our taking advantage of all available funding resources. One of these resources is the reimbursement program for meals from the United States Department of Agriculture Food and Nutrition Services. This benefits you because it helps us keep the charge for child care at a lower rate.

Parent's income determines the amount of reimbursement we will receive for providing meals to enrolled participants. So that we can keep our fee schedule low and provide excellent food service for participants, we need the information on the **Child Enrollment and Confidential Income Statement** attached to this letter. Please complete these, sign and return as soon as possible. All information will be kept strictly confidential.

If your household receives Supplemental Nutrition Assistance Program (SNAP), Food Distribution Program on Indian Reservations (FDPIR), Alaska Temporary Assistance Program (ATAP) benefits or Temporary Assistance to Needy Families (TANF) benefits. or has a monthly income less than or equal to the levels below, the center receives more reimbursement for the meals served to your children.

Family Size	1	2	3	4	5	6	7	8
Monthly Income	2,405	3,258	4,111	4,963	5,816	6,668	7,521	8,373

For each additional family member, add: +$853

If you believe you are over income using the above chart you may write "over income" on Part 4 of the Confidential Income Statement and initial, without providing your actual income.

If you have foster children in your home, please check the box in Part 1 with their name, age, and birth. Do not include any income you receive for their care.

Your cooperation is appreciated.

Sincerely,

JBER Child Care Food Program Manager, Melanie DePuy

This institution is an equal opportunity provider.

The Child and Adult Care Food Program Enrollment/Confidential Income Statement for children

FY2021 CENTER NAME:______________________________ Enrollment/CIS # __________

PART 1. ENROLLMENT INFORMATION You must complete ALL five columns of Part 1 & Check if child is a foster child

Name(s) of Enrolled Child(ren)	Date of Birth	Before & After Care	Circle Normal Days of Care and Print Normal Hours of Care	Circle the Meals the Child Normally Receives while in Care	Check if Foster Child
		YES NO	SUN MON TUE WED THUR FRI SAT Normal Hours ______ to ______	Break AM Snack Lunch PM Snack Supper	☐
		YES NO	SUN MON TUE WED THUR FRI SAT Normal Hours ______ to ______	Break AM Snack Lunch PM Snack Supper	☐
		YES NO	SUN MON TUE WED THUR FRI SAT Normal Hours ______ to ______	Break AM Snack Lunch PM Snack Supper	☐
		YES NO	SUN MON TUE WED THUR FRI SAT Normal Hours ______ to ______	Break AM Snack Lunch PM Snack Supper	☐
		YES NO	SUN MON TUE WED THUR FRI SAT Normal Hours ______ to ______	Break AM Snack Lunch PM Snack Supper	☐

Infant Formula Selection: Complete if any child listed above is an infant under one year of age

This center provides ______________________________ (list brand) iron fortified infant formula.

Check one: ☐ I accept the center provided formula ☐ I decline the center provided formula

I understand that by declining the center provided formula, I agree to provide breast milk or formula for my child. If I provide formula it must be on the approved formula list for the center to be reimbursed for the meal.

CONFIDENTIAL INCOME STATEMENT Please check all that apply and then fill out the parts specified.

- ☐ A member of my household receives SNAP (formerly Food Stamps) and/or TANF benefits. → Please complete Part 2 and Part 6, and Part 7(optional)
- ☐ One or more of my children participates in Head Start / Early Head Start at this center. → Please complete Part 3 and Part 6, and Part 7(optional)
- ☐ My household includes one or more foster children → Please complete Part 1 (Foster) Part 6, and if non-foster children enrolled for care, Part 5, and Part 7
- ☐ My child(ren) may qualify for Free or Reduced-Price meals based on household income. → Please complete Part 4, Part 5, and Part 6, and Part 7(optional)
- ☐ My child(ren) will not qualify for Free or Reduced-Price meals. → Please complete Part 5, Part 6 only, and Part 7(optional)

PART 2 – HOUSEHOLD MEMBER(S) RECEIVING SNAP, FDPIR, and/or TANF BENEFITS

If any household member gets SNAP (Food Stamps) and/or TANF benefits, list the recipient's name, circle the benefit type(s), and give the case number.

Name of Benefit Recipient	Circle One or Both (if applicable)	SNAP / FDPIR/ TANF Case Number (required)
	SNAP TANF FDPIR	

PART 3. CHILD(REN) ENROLLED IN HEAD START (Enclose document letter from EHS/HS)

Name of Child	Name of Child	Name of Child

PART 4. If any child is receives free or reduced meals at school due to income eligibility check the appropriate box.

Free Meals at School ☐ Reduced Meals at School ☐ **Enclose document letter from School**

PART 5. Total Household Gross Income. *You must tell us how much and how often.* ☐ N/A My family does not qualify by income

Household Size: ______

Gross income (before Taxes & Deductions) how often it was received and Frequency
A=Annual; W=Weekly; E2=Every 2 Weeks; T=Twice A Month or M=Monthly

List Names (First & Last) of Everyone in the household	Gross Earnings from Work before deductions If none, write "0"		Welfare, Child support, Alimony If none, write "0"		Pensions, Retirement, Social Security, Other If none, write "0"		Check if approved for PFD	Check if approved for PFD
NAME	Income	Frequency	Income	Frequency	Income	Frequency	issued in 10/19	issued in 10/20
	$		$		$		☐	☐
	$		$		$		☐	☐
	$		$		$		☐	☐
	$		$		$		☐	☐
	$		$		$		☐	☐

PART 6. Signature and Last four digits of SSN (An adult household member must sign the CIS.)

If Part 5 is completed, the adult signing the form also must list the last four digits of their Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.) I certify (promise) that all information on this application is true and that all income is reported. I understand that the school will get Federal funds based on the information I give. I understand that school officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted.

PRINTED NAME OF PARENT/GUARDIAN	LAST 4 DIGITS ONLY XXX-XX-___ ___ ___ ___ ☐ I do not have a Social Security Number	DATE SIGNED
SIGNTURE OF PARENT/GUARDIAN	STREET ADDRESS, CITY, STATE, ZIP	DAYTIME PHONE

PART 7. CIVIL RIGHTS INFORMATION: ENROLLED CHILD(REN)'S ETHNICITY & RACE (OPTIONAL)	
Choose one ethnicity:	*Choose one or more (regardless of ethnicity):*
☐ Hispanic/Latino ☐ Not Hispanic/Latino	☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American ☐ White ☐ Native Hawaiian or other Pacific Islander

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.aser.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.

Privacy Act Statement:

The Richard B. Russell National School Lunch Act requires the information on this Confidential Income Statement. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced meals which would affect the reimbursement to the provider or center. You must include the last four digit of the social security number of the adult household member who signs the form. The social security number is not required when you apply on behalf of a foster child or you list a SNAP, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the form does not have a social security number. We will use your information to determine the rate of reimbursement that your child care or adult care provider receives for meals served to your child, or adult participant and for administration and enforcement of the Child and Adult Care Food Program.

INSTITUTION/SPONSOR ORGANIZATION USE ONLY

Write the total number of household members in the boxes below who qualify for PFD. Write zero (0) if none qualify.

Only use one year when calculating income. Use the year which corresponds with the date the CIS is completed below.

CIS completed BY December 31, 2020 Use PFD issued in October 2019	_____	CIS completed January 1, 2021or AFTER Use PFD issued in October 2020	_____

Total household members receiving PFDs_____ x $1,606.00 = _____ (issued in October 2019)

Total household members receiving PFDs_____ x $____.00 = _____ (issued in October 2020)

ELIGIBILITY by INCOME:

If there is more than one sequence of income or if the household received any PFDs you must convert all income to annual. (i.e. $200/T, $150/M, $200/M & PFDs = Annual Conversion)

If there is only one sequence of income and the household did not receive any PFDs then you must keep the income at the sequence received. (i.e. $200/T, $100/T= No conversion necessary- keep at T)

List the income by sequence from first page:

Total Income by Category:	**Conversion to Annual:**
A-Annual:_____	x 1 = _____
M-Monthly:_____	x 12 = _____
T-Twice Per Month:_____	x 24 = _____
E2-Every 2 Weeks_____	x 26 = _____
W-Weekly_____	x 52 = _____
TOTAL HOUSEHOLD INCOME:	$_____

Check the sequence of income from above: ☐ Annual ☐ Monthly ☐ Twice Per Month ☐ Every 2 Wks ☐ Weekly

Total Income from above: $_____ + PFD income:$_____ = **TOTAL INCOME:$**_____ **Household size:** _____

OR ELIGIBILITY by CATEGORICAL DOCUMENTATION:

Check category from 1st page – must have case number or documentation from Head Start agency or school

Household Eligible:

☐ SNAP Household ☐ ATAP/TANF Household ☐ FREE at School ☐ REDUCED at School

Child Individual Eligibility:

☐ Migrant/Homeless per school ☐ Foster Child(ren) ☐ Head Start/EHS

The Institution's Determining Official MUST sign and date the Enrollment/CIS to complete it. Signature of a Verifying Official is recommended.

CLASSIFICATION: ☐ Free ☐ Reduced Price ☐ Over Income (household income) ☐ Over Income (incomplete information)

_____ _____

Signature of Determining Official Date

_____ _____ **Date Child(ren) withdrew or terminated:** _____

Signature of Verifying Official Date