

"Where Learning is Child's Play"
UNITED STATES COAST GUARD
CHILD DEVELOPMENT CENTER

Training Center, Petaluma
599 Tamales Road, Petaluma CA 94952
Telephone: (707) 765-7334 *1 Fax: (707) 765-7093

Thank you for choosing our Child Development Center (CDC) for your child care needs. This registration packet is for your child's enrollment. It is important to follow the registration process and complete all forms correctly and accurately. Along with the forms included in this packet, you will be required to provide immunization verification/updates along with other documents that substantiate your household income.

This Registration Packet includes the following

- _____ Child Development Services Registration Form
- _____ Release of Information/Privacy Act Statement
- _____ Child Development Services Collection of Financial Data
- _____ Child Development Services Child Health Form *2 pages* (To be filled out by Doctor)
- _____ Medical Consent Authorization - Military Members *2 pages* (Needs to be notarized)
- _____ Medical Consent Authorization - Civilian Members *2 pages* (Needs to be notarized)
- _____ Field Trip Permission Form
- _____ Photo, Video & Web Site Authorization
- _____ Basic Care Items
- _____ Child Information Record
- _____ Income Eligibility Guidelines for Food Program/How to Complete the Meal benefit form & Meal Benefit Form *4 pages*
- _____ CDC Fee Schedule/Household Income Worksheet for Military and Civilian Parents *2 pages*
- _____ CDC Contract *2 pages*

Other Information included in packet

- Child Development Services and Children with Special Needs
- WIC - Women, Infant & Children Supplemental Nutrition Program

Other documentation you will need:

- Current immunization records
- Household income verification (LES and/or W2s)
- Completed Orientation Form

When you have completed all applicable registration forms, please call the front desk at 707-765-7334 *1 to schedule a Parent Orientation. If you have any questions about the registration process or about the Child Development Center Program, please feel free to call the front desk at 707-765-7334 *1.



Accredited by the National
Academy for the Education
of Young Children

CHILD DEVELOPMENT SERVICES REGISTRATION FORM

Date: _____

(See Privacy Act Statement on Page 2.)

Child's Name: _____
Last First MI

Address: _____

Home Phone: _____ Birthdate: _____

Parent's Name: _____
(include Rank/Rate) Father Mother

Employers' Name/Address Cell: _____ Cell: _____

Father: _____ Mother: _____

Work Phone: _____ Work Phone: _____

Name of person(s) authorized to remove from child care (include phone number): At least 2
local people

Emergency contact in the event parent/guardian cannot be reached.
(Name/phone number)

Doctor's name/phone number: _____

Any other information you believe would be helpful to caregiver in working with your child(ren):

1. All parts of this form will be completed and signed by the sponsor before the child(ren) is admitted to the child care program.
2. This form will be kept on file for all children enrolled in a child care program.
3. A copy of the Emergency Medical Authorization form must be carried by staff if child is away from the site on a field trip so that emergency medical treatment may be obtained, if needed.
4. This form to be renewed at the beginning of each year.

RELEASE OF INFORMATION/PRIVACY ACT STATEMENT

Data required by the Privacy Act of 1974 (5 U.S.C. 552a)

Authority: 14 U.S.C. 632

Principle Purposes: To provide the care providers with authorization for medical treatment in emergency situations, identify children and sponsor, record required immunizations and known allergies, and to provide other information necessary for working with the child.

Routine Purposes: Form may be furnished to military or civilian doctor or hospitals in the course of obtaining medical treatment for children. Information furnished may be disclosed to any DHS component or part thereof, and upon request to other Federal, State, and local governmental agencies in the pursuit of their official duties.

Disclosure is Voluntary: The supplying of requested information is voluntary. Failure to respond will result in the denial of admission of your child to the program.

I release the information on the attached registration forms to the provider of child care services for the purpose of assessing the eligibility of the child(ren) for the program and for the routine uses listed above.

(Date)

(Signature)

CHILD DEVELOPMENT SERVICES **COLLECTION OF FINANCIAL DATA**

Release of information

Data required by the Privacy Act of 1974 (5 U.S.C. 552a)

Authority: 14 U.S.C. 632

Principal Purposes: To access the proper fee to charge each participant using the facilities and programs at the Coast Guard Training Center Child Development Center

Routine Purposes: Information obtained from Federal Income Tax Forms, Leave and Earnings Statement and Employee Pay Stubs will be used to determine the combined total family income of patrons, in order to access the proper fee to charge for Child Development Center Services.

Disclosure Is Voluntary: The supplying of requested information is voluntary. Failure to respond or provide the requested information will result in charging the patron of the Child Development Center the fee associated with the highest Income Category.

I release the financial information to the Child Development Center Management for the purpose of determining the fees to charge my child(ren) for the programs at the Child Development Center and for the routine uses listed above.

(Date)

(Signature)

CHILD DEVELOPMENT SERVICES
CHILD HEALTH FORM

To be completed by a health practitioner before admission to a child care program and renewed annually.

_____ has had a complete history and physical examination at my office on
(Child's name: Last/First/Middle)

_____. Findings for this child are indicated as follows:
Date _____

1. Date of most recent tuberculin test _____ . Result: Positive _____ Negative _____

2. The child has the following which may significantly affect his education/care experience:

	YES	NO	COMMENTS
a. Visual problem	_____	_____	_____
b. Hearing problem	_____	_____	_____
c. Speech or language problem	_____	_____	_____
d. Other physical illness or impairment	_____	_____	_____
e. Mental, emotional, behavior problem	_____	_____	_____
f. Developmental delays	_____	_____	_____
g. Allergies	_____	_____	_____

Significant physical findings, comments, and recommendations:

3. YES / NO The child has a health condition, which may require care or emergency action while he is at child care.
(Please specify, e.g., seizures, bee sting allergy, diabetes, etc.)

Recommendations:

4. YES / NO The child has or is a known carrier of a communicable disease.

Explain:

5. YES / NO The child is on long term medication. Specify:

6. YES / NO The child requires a modified diet and/or special feeding procedures. Specify:

7. YES / NO The child is in good physical and mental health. Except as noted above, he is free of communicable disease, has no problem that may interfere with his learning, and may participate fully in all activities.

ANSWER THE FOLLOWING QUESTIONS ONLY IF RELEVANT:

8. If child cannot fully participate in all areas of child care program, what areas should be limited or altered to suit this child's needs?
9. YES / NO Does child's physical activity need to be restricted? If YES, explain
10. What specialized treatments, if any, will this child require?

Instructions for care:

11. Does this child require any supportive equipment? (Braces, crutches, etc.) YES NO

If YES, please specify type _____

Special instructions for use _____

12. Additional comments:

SIGNATURE & STAMP REQUIRED

Health Practitioner (please print) Phone

Signature of Health Practitioner Date

Address

CHILD DEVELOPMENT SERVICES
MEDICAL CONSENT AUTHORIZATION

(TO BE USED BY MILITARY FAMILY MEMBERS ONLY)

Instructions: Fill out all spaces. If an item is not applicable, put "N/A" in the space. **This form is a legal document and must be filled out completely and correctly to be valid.**

TO: HEALTH CARE PROVIDER

I, _____, am the parent or legal guardian of the child named below, and entitled to medical care at your facility/practice.

Child's Full Name: _____, Age: _____

Address: _____, Phone: _____

_____, ID Card # _____

_____, Exp. Date _____

(Sponsor's Name)

(Employee ID Number)

(Duty Station)

I do appoint the Child Development Center Director, or the most senior Child Development Center personnel present at the time of the emergency, to be my Attorney-in-Fact (agent) for the purpose of obtaining medical treatment deemed necessary in the event that I cannot be immediately reached in a reasonable amount of time at the time of the emergency.

The person(s) named above may authorize any medical or surgical procedures or treatments deemed necessary by the staff of the _____ Medical Clinic or any duly licensed medical practitioner for the health and well being of my child aforementioned. I understand that the staff of the _____ Medical Clinic include, in addition to Physicians and Dentists, Health Service Technicians and Physicians' Assistants who function under the supervision of a Physician and that these staff members may be called to evaluate and/or treat my child. I give this authorization in advance of any medical care or treatment in order to provide my Attorney-in-Fact the specific authority to consent to said care or treatment.

I HEREBY GIVE AND GRANT TO my said attorney-in-fact full power and authority to acknowledge and deliver any instrument under seal or otherwise, and to perform every act and thing whatsoever that is necessary or appropriate to accomplish the purposes for which this Consent Authorization is granted, as fully and effectually as I could do if I were present."

I understand that this authorization is valid only for the person(s) named herein and that it may be in force for up to one year. It is to take effect on _____, 20____ and, unless sooner revoked or terminated by me, this Power of Attorney shall become NULL and VOID on _____, 20____.

Signature of Parent or Guardian

Date

Approval Date _____

Chief, Medical Administration Branch
Health Services Division

This form shall be notarized.

State of _____)
County of _____) ss

On this _____ day of _____, _____
(Month and Year) (Name of Notary Public)

a notary public (or person authorized to administer oaths under 10 U. S. C 1044a) for the County/City and State aforesaid,
certify that _____
(Name of Person executing Document)

who is known to me (by proper identification) to be the person whose name is subscribed to the within instrument and acknowledged
that she executed the same for the purposes therein contained, as her free act and deed before me in the County/City and State
aforesaid.

Sworn to and subscribed before me this _____ day of _____
(Month and Year)

(Notary Public)

My Commission Expires: _____

CHILD DEVELOPMENT SERVICES AND CHILDREN WITH SPECIAL NEEDS (Encl. 1)

Coast Guard Child Development Centers (CDC) and Coast Guard Family Child Care (FCC) Homes include children with special needs (e.g., asthma, allergies, physical disabilities, vision and hearing problems, attention deficit disorder, developmental disabilities, behavior challenges and mental health conditions, etc.) in their programs. To ensure that the special needs of your child could be adequately met and managed at our facilities, the following documents must be obtained and reviewed by the Special Needs Resource Team (SNRT), prior to your child's placement in our care:

1. CDC/FCC enrollment forms, Child Health Form (Encl.4), and child immunization records.
2. Medical documentation specifically addressing the following;
 - a. Nature of child's disability or special need.
 - b. The child's special requirements for care, diet, and medication.
 - c. Special accommodations that the facility must make to accept the child.
 - d. Physician's opinion that the child will benefit from the type of program offered.
3. Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP).

The goal of this process is to share information to ensure the success of your child's placement in our programs. You will be notified of the time of the meeting. You are encouraged to invite to the meeting a knowledgeable professional who could present details about your child's special needs. The team will make recommendations about your child's placement at the time of the meeting, or as soon as all required documentation is received and reviewed.

If for any reason, we would not be able to care for your child in our facility, we would provide you with information about alternative programs.

For further information about the Special Needs Resource Team (SNRT) or Coast Guard Special Needs Program, please contact:

**Family Resource Specialist
CDC Director**

FIELD TRIP PERMISSION

I give my permission for _____

(child care provider) to take my child(ren) _____

_____ (name) on field trips and/or other outings

as long as my child(ren) is/are accompanied by competent supervision. These outings may be walking, motor vehicle, bicycle, etc.

The above authorization shall remain in effect for one (1) year from below date, or until cancelled or amended by parent or legal guardian.

(Signature of parent/legal guardian)

(Date)

Photo, Video & Web Site Authorization

Child's Name: _____ Date: _____

Below are two opportunities for the CDC to use photos of your child. Each opportunity is separate and requires your signature for us to use your child's photo(s) in individual media/formats. Participation is strictly voluntary, and CDC staff will honor your wishes. You may decline part or all as you see fit. Please take a moment to carefully read and *sign* or *decline* each section. Thank you.

- **CDC Pictures & Video Cameras:** The CDC staff takes digital pictures of children to post on classroom walls, to use for assessment purposes, and to pass on to parents via email. We would also like to occasionally use video tape for special events, such as graduations and family functions. NAEYC encourages this to enrich our environments and to record special events.

Please sign if we can take and use your child's photo as indicated above.

Parent Signature: _____

- **CDC Picture Viewing Website:** The CDC has a website that is **password protected** where parent's can view pictures that are taken in the classroom. We find it is the easiest way for the CDC to share the pictures we take with parents. This photo gallery is located on the CGWeb which is behind a firewall and only accessible from Coast Guard workstations. Please note: that we cannot control the use of downloaded pictures by a parent. The same would be true with CD or print delivery. The password is changed quarterly to insure security.

Please sign if we can post your child's photos on the CG intranet as indicated above.

Parent Signature: _____

Basic Care Items

1. "Basic care items are limited to topical times used for the prevention of sunburn, diaper rash (ointments and lotions), and diaper care. Parents of children showing any indication of disease (infected sunburn, diaper rash, or gums) will be notified and referred to a health provider for diagnosis and treatment. Use of basic care items will be discontinued until the health provider determines further use will not be harmful."

2. Basic care times used in Child Development Center (CDC) programs must be labeled with the child's name. The basic care item must be applied at home and the child observed for a minimum of 24 hours before the item is applied in a CDC setting. This limits the chance of an unfavorable reaction to the basic care item in the CDC setting. Parents must complete the Administration of Basic Care Items permission slip. This slip is stored with the basic care items and maintained in the classes emergency contact binder.

3. The following are examples, but by no means a complete list, of basic care items:

Lotions
Vaseline
Baby oil
Diaper wipes

Diaper ointments (Desitin)
Sun screen/sun block
Lip balm

Note: The CDC Staff will not apply teething gels, which are placed on infants gums.

CDC Basic Care Items Permission Form

Memorandum For Record

Subject: Administration of Basic Care Items

Date: _____

In accordance with medical guidance, parents must sign a permission slip for the administration of basic care items on an annual basis. Please complete and submit the following information for placement in your child's records.

USCG TraCen Staff have my permission to use the following basic care item(s):

- Lip Balm
- Vaseline
- Diaper Wipes
- Sun Screen

- Lotion
- Baby Oil
- Diaper Ointment
- Other: _____

I certify that the items selected have been used before with no known reaction(s).

Child's Name _____

Parent Signature _____

Child Information Record

Date filled out: _____

Child's Full Name: _____ Nickname: _____

Child's Birth Date: _____

Parent's Names: _____

Parent's Occupation: _____

Brother(s) & Sister(s): _____

Pre-enrollment Visit: _____
(Date) Caregiver's Initials

Room Orientation: _____
(Date) Program Director/Caregiver's Initials

Experiences

Where did you live prior to coming to Petaluma? _____

Describe your child's past childcare experiences, if any. Has your child had other play/social experiences outside of a childcare setting? (cousins, play groups, etc.) _____

What would you like to see your child & Family gain out of his/her CDC experience?

Child's Temperament

Social & Emotional Adjustments:

Describe your child's Temperament: _____

How does your child relate/react to strangers? _____

What makes your child happy? _____

What upsets/frightens your child? _____

What are your child's favorite activities? _____

Developmental Areas:

Current Verbal/Language Skills: _____

Problem Solving Skills: _____

Self Help Skills: _____

Strengths & Concerns: _____

Routines

Describe your child's **feeding** routine (Frequency, use of utensils/cup, preferences/favorites):

Family Nutritional Preferences: _____

Describe your child's **diapering/potty training** routine (any special needs, has potty training begun, fully potty trained): _____

Describe your child's **sleeping** routine (Waking up, how you put to sleep, length of naps, bedtime, bed or crib, stuffed toy/ binky): _____

How does your Infant like to be held during feedings or putting them to sleep? _____

Family

Who lives in the home with your child? _____

What Language(s) are spoken at home? _____

Define your family's culture background? _____

Do you have a religious celebration you would like us to recognize? _____

Do you celebrate holidays? **Y** or **N** If so, which holidays? _____

If not, what important information would you like us to know? _____

Please tell us about any family routines/rituals that you would like us to be aware of? (for example, how you say goodbye or transition, how do you prepare for meals, special vacations, etc.)

Please use the back of this page.

Special Needs

Is there anything in particular that you are "keeping an eye on" regarding your child? _____

Does your child have any environmental / food allergies? _____

Any other concerns? _____

Training Center Petaluma Child Development Center Contract

SECTION 1. CONTRACT DOCUMENTS

The Training Center Petaluma Child Development Center (CDC) and a parent or guardian of the child named in Section 2 hereby agree to the provisions and requirements contained herein and in the CDC Standing Operating Procedures Guide.

SECTION 2. DAILY ENROLLMENT HOURS

The Training Center Petaluma Child Development Center agrees to furnish appropriate child development services for _____ on the following days and times starting on _____
 (Name of Child) (Date)

The services provided by the CDC are non-transferable and will be provided to the above named child only.

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
IN	06:45	06:45	06:45	06:45	06:45
OUT					
IN					
OUT	16:30	16:30	16:30	16:30	16:30
TOTAL DAILY HOURS	9.75	9.75	9.75	9.75	9.75

SECTION 3. MONTHLY CONTRACT PAYMENT AMOUNT

I agree to pay \$_____ monthly to the TraCen Morale Fund in the manner as described in the SOP Guide. I also elect to make bimonthly Installment payments on the following paydays: Mark (X)

_____ Military (1st & 2nd Payday) _____ GS _____ NAF (1st & 2nd Payday of month for GS & NAF)

SECTION 4. SPECIAL ARRANGEMENTS

Check Yes or No in the appropriate space if there are any special arrangements or notes concerning your child that the CDC Staff should be aware of: YES _____ NO _____. If YES, state in SECTION 8.

SECTION 5. DEFINITIONS

<u>WORD</u>	<u>DEFINITION</u>
<i>CDC</i>	Means Child Development Center and/or Child Development Center Director
<i>CONTRACT HOURS</i>	Are the <i>total weekly hours (TWH)</i> as stated on the <i>contractual agreement</i>
<i>CONTRACT PAYMENT</i>	The dollar amount as shown in Section 3 of the <i>Contractual Agreement</i>
<i>CONTRACTUAL AGREEMENT</i>	An agreement, in writing, between the <i>CDC</i> and a <i>patron</i> , which specifies certain facts (<i>Terms</i>) associated with providing and receiving child developmental services
<i>FEDERAL HOLIDAYS</i>	Those days which are recognized by the Federal Government as a legal holiday for Federal workers as well as the day after Thanksgiving.
<i>MWR</i>	Means Morale, Well-being, and Recreation Branch
<i>PARTY</i>	Means either the <i>CDC</i> or <i>patron</i>
<i>PATRON</i>	A parent(s) or guardian(s) of a child or children using the <i>CDC</i> services
<i>PAYMENT DUE DATE</i>	The date, of the corresponding election of the selected pay system, in Section 3, by which the indicated <i>contract payment</i> , is due at the <i>CDC</i> .
<i>SOP</i>	Standard Operating Procedures
<i>TERMINATION</i>	A <i>contractual agreement</i> which is no longer binding or in effect between the <i>parties</i>
<i>TOTAL WEEKLY HOURS</i>	The accumulated hours of each weekday (Monday-Friday)

SECTION 6. CONTRACT TERMS

Selected terms of the contractual agreement are listed here to provide the patron with a general understanding of the major terms of the contractual agreement. Other terms are included in the CDC SOP Guide and are a part of the contractual agreement.

6.1 Administrative Authority

The Child Development Center operate under the policy guidance from Commandant (G-WPW-2) and are a function of the Morale, Well-Being, and Recreation (MWR) Program. As part of the MWR program, these facilities are an important quality-of-life factor for Coast Guard families. Parents are encouraged to discuss and communicate their concerns to the CDC Director. Parent concerns not resolved should be addressed up the administrative chain of command as indicated in Enclosure (6).

6.2 Contracting Parties

The contracting parties are the CDC Management and the parent(s) or guardian(s) of the child attending the CDC.

6.3 Effective Start Date of Contract

The effective start date of the contract is stated in Section 2 on the contract and mutually agreed upon by both parties.

6.4 Modification of Contract

- (1) Any contractual agreement may be modified or changed provided that:
 - (a) Both parties agree to the modification or change, and/or
 - (b) The modification or change is initiated at least two weeks before the effective date of the modification.
- (2) Modification of a contract will require a new contract to be completed indicating the changes.

6.5 Termination of a Contract

Either party may terminate the contract provided that a **written notice is given to the other party two weeks in advance** of the termination date. Payments are due on your scheduled payment due date. A one-day grace period (excluding weekends) is given to make your payment. If payment is not received following the one-day grace period, a fee of \$15.00 will be charged to your account. On the next payday, if the preceding installment payment and the current payment is not received, a late payment fee of \$15.00 will be again be charged to your account and a notice of termination will be provided to the patron indicating that services will no longer be provided starting the 1st of the next month. A letter of indebtedness will be sent to the patron's command and all other appropriate collection and administrative actions will be taken. If full restitution of fees is made prior to the 1st of the next month, CDC services will continue to be provided. Charges accrued up to a termination date are due and payable.

6.6 Determination of Contract Amount

The contract payments are determined by: (1) summing the total of the hours for each day of the week to determine the weekly total hours, and then (2) determining total family income and then, (3) finding the monthly contract amount in the fee chart, Enclosure (2).

6.7 Monthly Contract Payments

The contract monthly amount as determined in Section 6.6 above would cover services provided at the CDC, for the entire month beginning on the first day of the month and ending on the last day of the month.

6.8 Payment Due Date

Bimonthly installment payments must be paid in advance and are due no later than each elected payday schedule each month. The bimonthly payment amount will be 1/2 of the total monthly fee. Patrons may elect to pay on a monthly basis.

6.9 Delinquent Payments

If a child's account is not paid within the one day grace period (weekends & holidays excluded), a late fee of \$15.00 will be assessed to the patron's account. It is the patron's responsibility to contact the CDC Director regarding any problems with scheduled payments. Failure to make payments as agreed may result in the loss of Child Development Center privileges and use.

6.10 Overtime Charges

If space is available and a child exceeds the contracted weekly part-time hour range of 30 hours in any week, a rate of \$6.00 for each hour or portion of which exceeds the range, will be charged to the patron.

6.11 Other Charges

Other charges may include, but are not limited to, miscellaneous charges occurring from participation on field trips, use of supplies, etc.

SECTION 7. AGREEMENT OF UNDERSTANDING

I understand and agree to abide by the terms of this contract and the CDC SOP Guide.

I also understand that this contract will be in effect from the start date in Section 2 to 30 of Jan of each year.

SECTION 8. SPECIAL ARRANGEMENTS

Signature of Parent/Guardian

Date

Signature of CDC Director

Date

WIC Income Eligibility Guidelines 2011-2012

On March 24, 2011, a Notice announcing revised WIC Income Eligibility Guidelines was published in the Federal Register. The adjusted income eligibility guidelines are used by State agencies in determining the income eligibility of persons applying to participate in the WIC Program. WIC State agencies must implement the new guidelines not later than July 1, 2011. WIC State agencies may implement the revised income guidelines at the same time States implement revised income eligibility guidelines for the Medicaid Program. On January 20, 2011, the U.S. Department of Health and Human Services (HHS) published its annual update of the poverty guidelines (76 FR 3637). The HHS guidelines are used by a number of Federal programs, including WIC and the Medicaid Program, as the basis for determining and updating program income eligibility limits.

To be eligible on the basis of income, applicants' gross income (i.e. before taxes are withheld) must fall at or below 185 percent of the U.S. Poverty Income Guidelines. The guidelines for WIC are shown below.

[Click here if you are looking for WIC income eligibility guidelines for July 1, 2009 through June 30, 2011.](#)

WIC Income Eligibility Guidelines (Effective from July 1, 2011 to June 30, 2012)

48 Contiguous States, D.C., Guam and Territories					
Persons in Family or Household Size	Annual	Monthly	Twice-Monthly	Bi-Weekly	Weekly
1	\$20,147	\$1,679	\$840	\$775	\$388
2	27,214	2,268	1,134	1,047	524
3	34,281	2,857	1,429	1,319	660
4	41,348	3,446	1,723	1,591	796
5	48,415	4,035	2,018	1,863	932
6	55,482	4,624	2,312	2,134	1,067
7	62,549	5,213	2,607	2,406	1,203
8	69,616	5,802	2,901	2,678	1,339
Each Add'l Member Add	+\$7,067	+589	+295	+272	+136

To apply for WIC, contact
County of Sonoma, Department of Health Services

(707) 565-6590 1-(800)-816-3663
or www.Sonoma-county.org/wic

WIC has offices in
SANTA ROSA PETALUMA
SONOMA GUERNEVILLE

Child Development Services
Total Family Income Worksheet

NAME: _____

Senior Member/CIV

Rate:	Monthly Base Income		x12 =	
Children/age:	BI-Weekly Base Income (Civ)		x26=	
Name:	Monthly BAH Senior Member		x12=	
Name:	Monthly BAS		x12=	
Name:	Monthly Special Pay:		x12=	
Name:	Monthly Other Pay: std clothing		x12=	
	Monthly Other Pay:		x12=	
	Monthly Other Pay:		x12=	
	Monthly Other Pay:		x12=	

Patron's Initial	Sponsors Income		Monthly		Annual
------------------	------------------------	--	----------------	--	---------------

NAME: _____

Junior Member/Civ Spouse

Rate/CIV:	Monthly Base Income		x12 =	
	BI-Weekly Base Income (Civ)		x26=	
	Monthly BAS		x12=	
	Monthly Special Pay:		x12=	
	Monthly Other Pay:clothing std.		x12=	
	Monthly Other Pay:		x12=	
	Monthly Other Pay:		x12=	
	Monthly Other Pay:		x12=	
	Annual Income Statement (ie.w2)		x1=	

Patron's Initial	Spouse Income		Monthly		Annual
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Total Family Income	
TFI Sliding Fee Scale Category	
Monthly Rate Per Child	
Number of children	Total Rate

Patron's Signature _____ Date _____

TFI INCLUDES:
 Wages, salaries and Tips
 Long-term disability Benefits
 Incentive and Special Pay
 BAS
 BAH based on Military Pay Grade for Senior Member DO Not Read the LES for BAH information- See link for BAH2 Chart *
 * BAH II w/dependents for the Senior Member in a household
<http://perdiem.hqda.pentagon.mil/perdiem/bah.html>
 See NON-LOCALITY RATES link

TFI Does NOT include:
 Variable Housing Allowances (VHA or BAH as reflected on the LES)
 Junior Member's BAH in a Dual Active Duty Family
 Geographic Cost of Living Allowance (COLA)
 Alimony and Child Support
 Temporary Duty Allowances
 Reimbursements for Educational Expenses
 Veterans Benefits
 Workers Compensation
 Unemployment Compensation

CDC Staff Signature _____ Date _____

LETTER TO PARENTS (Child Care Center – Non-Pricing Program)

Dear Parent/Guardian:

The Two Rock Child Development center participates in the Child and Adult Care Food Program (CACFP) offered by the United States Department of Agriculture (USDA) and serves meals at no separate charge to all enrolled children. The reimbursement received from the CACFP helps with our food costs, and therefore, enables us to keep our fees for care as low as possible.

Please help us comply with the requirements of the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). Please complete, sign, and return the attached Meal Benefit Form to the center as soon as possible. **All children enrolled** in our center receive their meals at no separate charge, but the determination of eligibility category affects the amount of funding received by our center. This information is necessary to receive the reimbursement for the meals we served to children in our program. If your first language is not English, you have a right to ask us for written or oral translation of these materials free of charge in your native language.

If your household currently receives benefits under the Food Stamp Program; the California Work Opportunity and Responsibility for Kids (CalWORKs); the Kinship Guardian Assistance Payment (Kin-GAP); or the Food Distribution Program on Indian Reservations (FDPIR), you only need to list your current Food Stamp, CalWORKs, Kin-GAP, or FDPIR case number on the Meal Benefit Form. You must also have an adult sign and date the Meal Benefit Form.

However, if your household does not receive benefits under Food Stamp, CalWORKs, Kin-GAP, or FDPIR, please complete the Meal Benefit Form and make sure you:

- > provide the names of all household members and their income by source; and
- > have an adult sign, date, and provide his or her social security number, or check the box "Check here if no Social Security Number" if the adult does not have a social security number.

For All Households:

The USDA defines a household as a **group of related or unrelated individuals** (not residents of a boarding house or an institution) who are living as one economic unit (i.e., sharing living expenses). Therefore, the income reported on the Meal Benefit Form must include the gross income of all members of your household, by source.

The **income** you report must be the total gross income received last month, listed by source for each household member. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last year's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income Chart, the center receives a higher level of reimbursement for meals served to your child(ren).

Once properly approved for free or reduced-price benefits, whether through income or proof of benefits as supported by a current Food Stamp, CalWORKs, Kin-GAP, or FDPIR case number, your child(ren) will remain eligible for those benefits for 12 months.

Foster Children:

For households with foster children, please refer to the instructions on *How to Complete the Meal Benefit Form* or contact us for additional information.

Confidentiality of Information on the Meal Benefit Form:

We will use the information on the form to decide the level of reimbursement our center is eligible to receive. We will place the Meal Benefit Form in our food program files and keep the information confidential. Only upon your request, will we share the information on your form with officials of other child nutrition, health, and education programs so they can use it to determine benefits for those programs.

Income is computed by dividing annual income by 52. All numbers are rounded upward to the next whole dollar. The numbers reflected in this notice for a

family of four in the 48 contiguous States, the District of Columbia, Guam and the territories represent an increase

of 1.4% over last year's level for a family of the same size. BILLING CODE 9410-30-P

INCOME ELIGIBILITY GUIDELINES											
		Effective from					to				
		July 1, 2011					June 30, 2012				
HOUSEHOLD SIZE	FEDERAL POVERTY GUIDELINES	REDUCED PRICE MEALS - 185 %					FREE MEALS - 130 %				
	ANNUAL	ANNUAL	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY	ANNUAL	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY
48 CONTIGUOUS STATES, DISTRICT OF COLUMBIA, GUAM, AND TERRITORIES											
1	10,890	20,147	1,679	840	775	388	14,157	1,180	590	545	273
2	14,570	27,214	2,268	1,134	1,047	524	19,123	1,594	797	736	368
3	18,530	34,281	2,857	1,429	1,319	660	24,089	2,008	1,004	927	464
4	22,650	41,348	3,446	1,723	1,591	796	29,055	2,422	1,211	1,118	559
5	26,970	48,415	4,035	2,018	1,863	932	34,021	2,836	1,418	1,309	655
6	31,590	55,482	4,624	2,312	2,134	1,067	38,987	3,249	1,625	1,500	750
7	36,510	62,549	5,213	2,607	2,406	1,203	43,953	3,663	1,832	1,691	846
8	41,730	69,616	5,802	2,901	2,678	1,339	48,919	4,077	2,039	1,882	941
For each add'l family member, add		7,067	599	295	272	136	4,966	414	207	191	96
ALASKA											
1	13,600	25,160	2,097	1,049	988	484	17,680	1,474	737	680	340
2	18,380	34,003	2,834	1,417	1,308	654	23,894	1,992	996	919	460
3	23,160	42,846	3,571	1,786	1,648	824	30,108	2,509	1,255	1,158	579
4	27,940	51,689	4,308	2,154	1,989	995	36,322	3,027	1,514	1,397	699
5	32,720	60,532	5,045	2,523	2,329	1,165	42,536	3,545	1,773	1,636	818
6	37,500	69,375	5,782	2,891	2,669	1,335	48,750	4,063	2,032	1,875	938
7	42,280	78,218	6,519	3,260	3,009	1,505	54,964	4,581	2,291	2,114	1,057
8	47,060	87,061	7,256	3,628	3,349	1,675	61,178	5,099	2,550	2,353	1,177
For each add'l family member, add		8,843	737	369	341	171	6,214	518	259	239	120
HAWAII											
1	12,540	23,199	1,934	967	893	447	16,302	1,359	680	627	314
2	16,930	31,321	2,611	1,306	1,205	603	22,009	1,835	918	847	424
3	21,320	39,442	3,287	1,644	1,517	759	27,716	2,310	1,155	1,066	533
4	25,710	47,564	3,964	1,982	1,830	915	33,423	2,786	1,393	1,286	643
5	30,100	55,685	4,641	2,321	2,142	1,071	39,130	3,261	1,631	1,505	753
6	34,490	63,807	5,318	2,659	2,455	1,228	44,837	3,737	1,869	1,725	863
7	38,880	71,928	5,994	2,997	2,767	1,384	50,544	4,212	2,106	1,944	972
8	43,270	80,050	6,671	3,336	3,079	1,540	56,251	4,688	2,344	2,164	1,082
For each add'l family member, add		8,122	677	339	313	157	5,707	476	238	220	110

*ALL CDC CHILDREN RECEIVE BREAKFAST, LUNCH AND SNACK REGARDLESS OF FAMILY INCOME.

*The guidelines on this page merely reflect our rate of reimbursement for serving meals.

HOW TO COMPLETE THE MEAL BENEFIT FORM

Please complete the Meal Benefit Form using the instructions below. Sign the form and return it to:

If you need help, call: _____

1. CHILD INFORMATION:

- a) Print your child's name.
- b) Include the name of the child care center.

2. FOSTER CHILDREN: Complete this Section and sign the form in #5.

- a) Write the foster child's monthly "personal use" income. Write "0" if the foster child does not get "personal use" income.
- b) A foster parent or other official representing the child must sign the form in #5. You do not have to list a Social Security Number.
- c) Complete a separate form for each foster child.

3. OTHER BENEFITS: Complete this Section and sign the form in #5.

- a) List your current Food Stamp, CalWORKs, Kin-GAP, or FDPIR case number(s) for your child(ren).
- b) Sign the form in #5. An adult household member must sign. You do not have to list a Social Security Number.

4. ALL OTHER HOUSEHOLDS: Complete this Section and sign the form in #5.

- a) Write the names of everyone in your household even if they do not have an income. Include yourself, your spouse, the child you are applying for, and all other household members.
- b) Write the amount of income each person received last month before taxes or anything else was taken out and where it came from, such as earnings, welfare, pensions, and other income (see examples below for types of income to report). Each income amount should be entered in the appropriate column on the form. If any amount **last month** was more or less than usual, write that person's usual monthly income.
- c) If anyone is self-employed, write the amount of income that person earns from self-employment. Please call the number listed at the top of the form if you need help.
- d) Sign the form and include your Social Security Number in #5. *If you do not have a Social Security Number, check the box "Check here if no Social Security Number."*

5. SIGNATURE AND SOCIAL SECURITY NUMBER:

- a) The form must have a **signature** of an adult household member.
- b) 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, check the box "Check here if no Social Security Number".* A Social Security Number is not needed if you listed a Food Stamp, CalWORKs, Kin-GAP, or FDPIR case number, or if you are applying for a foster child.

- 6. **RACIAL/ETHNIC IDENTITY:** You are **not** required to answer this question to get meal benefits, but completion of this information will help ensure that everyone is treated fairly.

INCOME TO REPORT

Earnings from Work:

- Wages/salaries/tips
- Strike benefits
- Unemployment compensation
- Worker's compensation
- Net income from self-owned

Welfare/Child Support/Alimony

- Public assistance payments
- Welfare payments
- Alimony/child support payments

Pensions/Retirement/Social Security

- Pensions
- Supplemental security income
- Retirement income
- Veteran's payments
- Social Security

Other Monthly Income/Self-Employment

- 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
- Military allowance for off-base housing
- Any other income

MEAL BENEFIT FORM FOR YEAR _____

Complete, sign, and return the form to _____.

Please read the instructions. If you need help completing this form, call: _____.

1. CHILD INFORMATION:

CHILD'S NAME: _____
Last First M.I.

FOR MEAL BENEFITS IN CHILD CARE:

Name of Child Care Center: _____

2. **FOSTER CHILDREN:** (See the instructions). If this is a foster child, check here and write the child's monthly personal use income here: \$ _____. Go to Section #5.

3. **OTHER BENEFITS:** If you are getting Food Stamp, CalWORKs, Kin-GAP, or FDPIR benefits for your child, list the case number. DO NOT complete Section #4. Go to Section #5.

Food Stamp Case Number: _____

FDPIR Case Number: _____

CalWORKs Case Number: _____

Kin-GAP: _____

4. **ALL OTHER HOUSEHOLDS:** (Complete this section only if you did not complete Sections #2 or #3.) List all household members. List all income. Go to Section #5.

NAMES	CURRENT MONTHLY INCOME				
	NAMES OF HOUSEHOLD MEMBERS (INCLUDE THE CHILDREN LISTED ABOVE)	MONTHLY EARNINGS FROM WORK (BEFORE DEDUCTIONS) JOB 1	MONTHLY WELFARE, CHILD SUPPORT, ALIMONY	MONTHLY PAYMENTS FROM PENSIONS, RETIREMENT, SOCIAL SECURITY	MONTHLY EARNINGS FROM JOB 2 OR ANY OTHER MONTHLY INCOME
1.		\$	\$	\$	\$
2.		\$	\$	\$	\$
3.		\$	\$	\$	\$
4.		\$	\$	\$	\$
5.		\$	\$	\$	\$
6.		\$	\$	\$	\$
7.		\$	\$	\$	\$
8.		\$	\$	\$	\$
9.		\$	\$	\$	\$
10.		\$	\$	\$	\$
11.		\$	\$	\$	\$

5. SIGNATURE AND SOCIAL SECURITY NUMBER:

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that the Food Stamp, CalWORKs, Kin-GAP, FDPIR, or other eligible program case number is current, correct, or that all income is reported. I understand that this information is being given for the receipt of Federal funds; that agency officials may verify the information on the Meal Benefit Form and that the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

Signature of Adult: _____

Check here if no
Social Security Number

Social Security Number: _____

Printed Name: _____

Home Phone: _____ Work Phone: _____

Printed Name: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Date: _____

Privacy Act Statement: Unless you list the child's Food Stamp, CalWORKs, Kin-GAP, or FDPIR case number, or are applying for a foster child, Section 9 of the National School Lunch Act requires that you include the social security number of the household member signing the form, or indicate that the household member signing the form does not have a social security number. You do not have to list a social security number, but if a social security number is not listed, or the "Check here if no Social Security Number" is not marked, we cannot approve the form. The social security number may be used to identify the household member in verifying the correctness of the information stated on the form. This may include program reviews, audits and investigations, and may include contacting employers to determine income, contacting a Food Stamp, CalWORKs, Kin-GAP, or FDPIR office to determine current certification for Food Stamp, CalWORKs, Kin-GAP, or FDPIR 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 social security number may also be disclosed to programs as authorized under the National School Lunch Act and the Child Nutrition Act, the Comptroller General of the United States, and law enforcement officials for the purpose of investigating violations of certain Federal, State, and local education, and health and nutrition programs.

6. RACIAL/ETHNIC IDENTITY: You are not required to answer these questions. If you choose to do so, please mark one or more of the following racial identities:

- American Indian or Alaska Native Asian Black or African American
 Native Hawaiian or Other Pacific Islander White

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

In accordance with Federal law and U.S. Department of Agriculture policy, this agency is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.

To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

For Official Use Only:

Food Stamp/CalWORKs/Kin-GAP/FDPIR household categorically eligible free: Yes No

MONTHLY INCOME CONVERSION: WEEKLY X 4.33, EVERY 2 WEEKS X 2.15, TWICE A MONTH X 2

Total monthly income: _____ Household size: _____

Eligibility Classification: Free Reduced Price Paid

Determining official (print name): _____

Signature: _____ Date: _____

For GDE Only

2011 TraCen, Petaluma
CDC Fee Schedule

INCOME	TIER	Weekly	Monthly	Annual	Hr cost	Maximum Hrs Per		Daily
		Amount	Rate	Rate		Week	Month	Rate
Full Time								
0-29,400	I	\$76.21	330	\$3,960.00	\$1.56	48.75	211	15.24
29,401-35,700	II	\$92.38	400	\$4,800.00	\$1.89	48.75	211	18.48
35,701-46,200	III	\$108.55	470	\$5,640.00	\$2.23	48.75	211	21.71
46,201-57,750	IV	\$124.71	540	\$6,480.00	\$2.56	48.75	211	24.94
57,751-73,500	V	\$140.88	610	\$7,320.00	\$2.89	48.75	211	28.18
73,501-85,000	VI	\$157.04	680	\$8,160.00	\$3.22	48.75	211	31.41
85,001-100,000	VII	\$161.66	700	\$8,400.00	\$3.32	48.75	211	32.33
100,001-125,000	VIII	\$166.28	720	\$8,640.00	\$3.41	48.75	211	33.26
125,000+	IX	\$170.90	740	\$8,880.00	\$3.51	48.75	211	34.18
Part Time (up to 30 hours per week)								
0-29,400	I	\$57.74	250	\$3,000.00	\$1.92	30	130	11.55
29,401-35,700	II	\$69.28	300	\$3,600.00	\$2.31	30	130	13.86
35,701-46,200	III	\$81.99	355	\$4,260.00	\$2.73	30	130	16.40
46,201-57,750	IV	\$93.53	405	\$4,860.00	\$3.12	30	130	18.71
57,751-73,500	V	\$106.24	460	\$5,520.00	\$3.54	30	130	21.25
73,501-85,000	VI	\$117.78	510	\$6,120.00	\$3.93	30	130	23.56
85,001-100,000	VII	\$121.25	525	\$6,300.00	\$4.04	30	130	24.25
100,001-125,000	VIII	\$124.71	540	\$6,480.00	\$4.16	30	130	24.94
125,000+	IX	\$128.18	555	\$6,660.00	\$4.27	30	130	25.64

Drop in rate \$6.00/hr or any portion thereof
Late Pick up Fee \$10 per 10 minutes or portion thereof.