North Carolina
Department of Health and Human Services
Women's and Children's Health
CHILD AND ADULT CARE FOOD PROGRAM
CHILD ELIGIBILITY APPLICATION

1. PRINT THE PARTICIPANT'S NAME AND DATE OF BIRTH:

First Name Last Name Date of Birth

First Name Last Name Date of Birth

First Name Last Name Date of Birth

NAME OF INSTITUTION: _____

FACILITY NAME: _____

AGREEMENT NUMBER: _____

2. FOOD STAMP, TANF or FDPIR : If the household currently receives FOOD STAMP, TANF or FDPIR benefits give the case number. Yes, we receive food stamps, TANF or FDPIR benefits. Case number is: **Food Stamp #** _____
TANF # _____ **FDPIR** #_____
If yes, and you have provided the case number, **DO NOT complete #3 and #4. Complete #5(voluntary) and #6**. If a child is a member of a food stamp or FDPIR household or TANF assistance unit, the child is automatically eligible to receive free Program meal benefits, subject to the completion of the application.

3. IS THIS A FOSTER CHILD? ☐ Yes ☐ No. If yes, give the child's income $_____ and **DO NOT complete #4**. **Complete #5**. **A separate application must be completed for each foster child. In certain cases, foster children are eligible for free and reduced-price meals regardless of household income.**

4. HOUSEHOLD MEMBERS MONTHLY INCOME: List all others living in your household, **DO NOT** include participant listed above. List all gross income **(before deductions)** received last month. If you did not give a food stamp, TANF or FDPIR case number or if this is not a foster child, you must complete the income information.

Names of all Other Household Members	Monthly Wages Salaries	Monthly Social Security Earnings	Monthly Public Assistance/ Child Support Earnings	Monthly Retirement Pensions Earnings	Monthly Other Earnings
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$

5. ETHNIC IDENTITY: (Please check one).
☐Hispanic or Latino ☐Not Hispanic or Latino

RACE OF PARTICIPANT: (Please check one or more).
☐ White ☐ Black or African American ☐ American Indian or Alaskan Native
☐ Asian ☐ Native Hawaiian or Other Pacific Islander

6. SIGNATURE AND SOCIAL SECURITY NUMBER: I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds; that Program officials may verify the information on the application and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal criminal laws.

Signature of Adult Household Member (Required) Date: **Social Security Number (**(Required (all 9 digits) for households qualifying by income)

Printed Name Home Telephone # Work Telephone #

Address City Zip Code

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but it you do not, we cannot approve your child for free or reduced price meals. You must include the social security number of the adult household member who signs the application. The social security number is not required when your apply on behalf of a foster child or you list a Food Stamp, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child or other FDPIR identifier or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals and for administration and enforcement of the Program. If a child is a Head Start participant, the child is automatically eligible to receive free Program meal benefits, subject to submission by Head Start officials of a Head Start statement of income eligibility or income eligibility documentation.

For Institution To be classified and completed by institution/sponsor

TOTAL HOUSEHOLD SIZE _____TOTAL HOUSEHOLD MONTHLY INCOME $ _____
Approved: ☐ Free ☐ Reduced ☐ Denied
Reason for denial: ☐ Income too high ☐ Incomplete application ☐ Other
Withdrew on (Date):

For state use only:
Verified by:_____
Date:_____
Verified classification: ☐ Free ☐ Reduced ☐ Denied
Reason for change in classification:

Signature of Eligibility Official Date

PARENT GUARDIAN/HOUSEHOLD LETTER FOR NON-PRICING INSTITUTIONS
CHILD AND ADULT CARE FOOD PROGRAM

Dear Parent or Guardian,

Please help us comply with the federal requirement mandating the annual submission of Program Eligibility Application (CAC 11). This application will be used only for eligibility determination, placed in our files and treated as confidential information. In order for participants and the day care center to be considered eligible for program benefits, an adult household member must complete the Program Eligibility Application for each participant enrolled in the center as soon as possible, sign, date and return it to the day care center. Completion of the application is not mandatory unless you wish to be considered for eligibility as a free or reduced price participant.

If you currently receive food stamps, Temporary Aid to Needy Families (TANF) or Food Distribution Program on Indian Reservations (FDPIR), you are not required to list household income. You may give your food stamp, TANF or FDPIR case number, sign, date and return the application. If a child is a member of a food stamp or FDPIR household or is a TANF recipient, the child is automatically eligible to receive free Program meal benefits, subject to completion of the application.

You should also note that if you have a foster child the day care center may be eligible for program benefits for the foster child regardless of the income of your household. Please contact the institution for further instructions.

You should list the name of everyone who lives in your household, including all children, parents, grandparents and other relatives. The Department of Agriculture defines a household as a group of related or unrelated individuals (not residents of an institution or boarding house) who are living as one economic unit (i.e. sharing living expenses).

The income which you report **must** be the total gross income, before deductions, received by all members of your household last month (i.e. wages, welfare or retirement etc). Military benefits received in cash, such as housing allowance for military households living off base and food or clothing allowance, **must** be considered as income. If you have a household member for whom last month's income was higher or lower than usual, list that person's expected average monthly income. Households with incomes less than or equal to the levels in the chart below, are eligible for free or reduced price meals.

EFFECTIVE JULY 1, 2009 - JUNE 30, 2010
REDUCED GUIDELINES

HOUSEHOLD SIZE	YEARLY	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY
1	20,036	1,670	835	771	386
2	26,955	2,247	1,124	1,037	519
3	33,874	2,823	1,412	1,303	652
4	40,793	3,400	1,700	1,569	785
5	47,712	3,976	1,988	1,836	918
6	54,631	4,553	2,277	2,102	1,051
7	61,550	5,130	2,565	2,368	1,184
8	68,469	5,706	2,853	2,634	1,317
For each Household member add:	+6,919	+577	+289	+267	+134

You may submit a program eligibility application any time during the fiscal year. Participants having family members who become unemployed are eligible for free or reduced-price meals during the period of unemployment, provided that the loss of income causes the family's income during the period of unemployment to be within the eligibility standards for those meals.

CACFP ELIGIBILITY APPLICATION INSTRUCTIONS

Please complete the Child and Adult Care Food Program Eligibility Applications using the instructions below. Sign the statement and return it to your child care center.

PART 1-PARTICIPANT'S INFORMATION: Complete this part.

Print the name(s) of the child enrolled in the center.

PART 2-HOUSEHOLD GETTING FOOD STAMPS, TANF, OR FDPIR BENEFITS: Complete this PART and PART 6.

(1) List your current food stamp, TANF, or FDPIR case identification number.
(2) An adult household member must sign the statement in PART 6.

PART 3-FOSTER CHILD

(1) Indicate if child is a Foster Child. A separate application must be completed for each foster child.
(2) If yes, do not complete PART 4.
(3) An Adult household Member must sign the statement in PART 6.

PART 4- HOUSEHOLD INCOME: Complete this PART and PART 6

(1) List the names of household members.
(2) Write the amount of income (the amount before taxes or anything else is taken out), the frequency of income (i.e. weekly, every two weeks, twice a month, or monthly) received **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 less than usual, write the person's usual income.
(3) An adult household member must sign this income eligibility statement and give his/her social security number in PART 6.

PART 5-RACIAL/ETHNIC IDENTITY: Complete the Ethnic/Racial identity question.

PART 6-SIGNATURE AND SOCIAL SECURITY NUMBER: All households complete this PART.

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

INCOME TO REPORT

Earnings from Employment
Wage/salaries/tips
Strike benefits

Unemployment compensation
Worker's 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.

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

Military Households
All cash income, including military housing/uniform allowances. Does not include "in-kind" benefits NOT paid in cash (base housing, clothing, food, medical care, etc.)

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

All programs of the United States Department of Agriculture are available to everyone with out regard to race, color, sex, national origin, age or disability.

CACFP ELIGIBILITY APPLICATION
CHILDREN ENROLLED IN FAMILY DAY CARE HOMES

PART I

Child's Name:_____
Last _____**First**_____**M.I.**_____**Date of Birth**_____

Child's Name:_____
Last_____**First**_____**M.I.**_____**Date of Birth**_____

Provider's Name: _____

PART 2A - HOUSEHOLDS NOW GETTING FOOD STAMPS, TANF/WORK FIRST, FDPIR, NATIONAL SCHOOL LUNCH OR WIC BENEFITS: Complete this part and sign the statement in PART 3 - DO NOT complete PART 2B. If a child or a child's parent is participating in or subsidized under a Federally or State supported child care or other benefit program with an income eligibility limit that does not exceed the eligibility standard for free or reduced price meals, meals served to the child are automatically eligible for tier I reimbursement, subject to the completion of the application.

Food stamp case #: _____ WIC#: _____

TANF/Work First identification #: _____ Receives Free/Reduced Priced School Lunch (NSLP) ☐ (Check if applies)

FDPIR identification #: _____ Receives Free/Reduced Priced School Breakfast (SBP) ☐ (Check if applies)

(Food Distribution Program on Indian Reservations)

Federally funded Head Start Program ☐ (Check if applies)

PART 2B - ALL OTHER HOUSEHOLD MEMBERS: If you did not complete PART 2A, complete this PART and PART 3.

NAMES	**CURRENT INCOME/FREQUENCY - (Last Month)**			
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**

PART 2C - FOSTER CHILD: Complete this PART and PART 3. If this is a foster child check here ( ) and write the child's income and how often it is received here: $ / . In certain cases, foster children are eligible for free and reduced-price meals regardless of household income.

PART 3 - SIGNATURE AND SOCIAL SECURITY NUMBER: **An adult household member must sign the statement before it can be approved.** I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds; that Program officials may verify the information on the application and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal criminal laws.

Signature of Adult:_____ Social Security #:_____-_____-_____
(Required) (Required (all 9 digits) for households qualifying by income)

Printed name of Adult:_____ Date Signed:_____

_____ _____ _____

Home Address Zip Code Home Telephone Work Telephone

PART 4 - . ETHNIC IDENTITY: (Please check one).

☐Hispanic or Latino ☐Not Hispanic or Latino

RACE OF PARTICIPANT: (Please check one or more).

☐ White ☐ Black or African American ☐ American Indian or Alaskan Native
☐ Asian ☐ Native Hawaiian or Other Pacific Islander

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but it you do not, we cannot approve your child for free or reduced price meals. You must include the social security number of the adult household member who signs the application. The social security number is not required when your apply on behalf of a foster child or you list a Food Stamp, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child or other FDPIR identifier or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals and for administration and enforcement of the Program. If a child is a Head Start participant, the child is automatically eligible to receive free Program meal benefits, subject to submission by Head Start officials of a Head Start statement of income eligibility or income eligibility documentation.

For Sponsoring Organization Use Only:
MONTHLY INCOME CONVERSION: WEEKLY X 4.33 EVERY 2 WEEKS X 2.15 TWICE A MONTH X 2

Total family income:_____ Family size:_____

Tier I _____ Eligible: _____

Tier II _____ Not Eligible: _____

Determining Official Signature: _____ Date: _____

For state use only:
Verified by:_____
Date:_____
Verified classification: ☐ Free ☐ Reduced ☐ Denied

CACFP ELIGIBILITY APPLICATION
CHILDREN ENROLLED IN FAMILY DAY CARE HOMES

Please complete the Child and Adult Care Food Program Eligibility Application using the instructions below. Sign the statement and return it to the sponsoring organization listed below. Call the organization if you need help: #_

Dear Parent/Guardian:

Your day care provider participates in the Child and Adult Care Food Program (CACFP) funded by the U.S. Department of Agriculture and administered by the North Carolina Department of Health and Human Services. Please help us comply with the CACFP requirements by completing, signing and returning the attached income statement to the address provided. This information is necessary so that your day care provider may be paid for the meals served to the children in their care. All children in our program receive their meals free of charge, but the income eligibility category determines the amount of funding your day care provider will receive. The information you provide on this form will be confidential and will **NOT** be shared with your day care provider or anyone else without your permission.

Complete the application as follows:

- **HOUSEHOLD MEMBERS:** List the name of the enrolled child(ren), and the child's parent(s) or guardian, and any other dependent children who live in the household.

- **FOOD STAMPS, TANF/WORK FIRST, FDPIR, WIC, FREE/REDUCED PRICE SCHOOL LUNCH:** If a household member is currently receiving benefits from any of these programs, provide the program case/identification number as requested. Do not complete Part 2B.

- **CURRENT INCOME:** List the amount of income each person earned **last** month **(BEFORE)** deductions for taxes, social security, etc.), the frequency of income, and where it is from, such as wages, retirement, or welfare. If any household member's income last month was higher or lower than usual, list that person's usual average monthly income.

- **SIGNATURE:** An adult household member must sign the income eligibility application.

- **SOCIAL SECURITY NUMBER:** List the social security number of the adult who signs the income eligibility statement. If that adult does not have a social security number, print "None"

EFFECTIVE JULY 1, 2009 - JUNE 30, 2010
REDUCED GUIDELINES

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8	68,469	5,706	2,853	2,634	1,317
For each Household member add:	+6,919	+577	+289	+267	+134

You may submit a program eligibility application any time during the fiscal year. Participants having family members who become unemployed are eligible for free or reduced-price meals during the period of unemployment, provided that the loss of income causes the family's income during the period of unemployment to be within the eligibility standards for those meals.

In accordance with Federal law and U.S. Department of Agriculture policy, this institution 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, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

There is now an affordable health insurance program for children, Health Choice, offered by the State of North Carolina. Health Choice is a comprehensive health plan which covers both hospitalization and outpatient care, including preventive dental, vision, and hearing benefits. This new health plan is intended for children whose parents' income is too high to qualify for Health Check, the state Medicaid program. Applications for Health Choice will be available beginning in October 1998. You may pick up applications from your local health or county social services departments. Get more information on either Health Choice or Health Check by calling this toll free phone number: (800) 367-2229.

CACFP ELIGIBILITY APPLICATION
CHILDREN ENROLLED IN FAMILY DAY CARE HOMES

PART 1 – PARTICIPANT'S INFORMATION: Complete this part.
(1)Print the name of each child enrolled in the Day Care Home.
(2) Print the name of the Day Care Home provider.

PART 2A - HOUSEHOLD GETTING FOOD STAMPS, TANF/WORK FIRST, FDPIR, NATIONAL SCHOOL LUNCH, SCHOOL BREAKFAST, HEADSTART OR WIC BENEFITS:
Complete this PART and PART 3.
(1)List your current food stamp case number or your TANF/Work First, FDPIR, or WIC identification number, or check yes to indicate that your child receives free/reduced priced school lunch. Do not complete Part 2B.
(2)An adult household member must sign the statement in PART 3.

PART 2B - HOUSEHOLD INCOME: **Complete this PART and PART 3**
(1)List the names of household members.
(2)For each household member provide the gross income (the amount before taxes or any other deductions), the frequency of income (i.e., weekly, every two weeks, twice a month, or monthly) received **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 the person's usual income.
(3)An adult household member must sign this income eligibility statement and give his/her social security number in PART 3.

PART 2C -FOSTER CHILD: Complete this PART and PART 3 for each foster child living in your home and enrolled in the center.

PART 3 - SIGNATURE AND SOCIAL SECURITY NUMBER: All households complete this PART.
(1)All eligibility statements must have the signature of an adult household member;
(2)The adult household member who signs the statement must include his/her full social security number. If he/she does not have a social security number, write "none". If you listed a food stamp, TANF/Work First, WIC, or FDPIR number a social security number is not needed.

PART 4 – ETHNIC/RACIAL IDENTITY: Complete the Ethnic/Racial identity question.

INCOME TO REPORT

Earnings from Employment
Wages/salaries/tips
Strike benefits
Unemployment compensation
Worker's compensation
Net income from self-owned business or farm

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

Military Households
All cash income, including military housing/uniform allowances. Does not include "in-kind" benefits paid in cash (base housing, clothing, food, medical care, etc.)

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
NOT Any other income

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.

Name and Address of Sponsoring Organization

CHILDREN, YOUTH & TEEN PROGRAMS (CYTP)
CHILD HEALTH ASSESSMANT

NAME OF SPONSOR & SPOUSE (Last, First, MI)	TELEPHONE (Home)	TELEPHONE (Duty)
NAME OF MEDICAL TREATMENT FACILITY/PHYSICIAN	ADDRESS (Include ZIP code)	TELEPHONE

CHILD HEALTH INFORMATION

NAME OF CHILD	BIRTHDATE	SEX	HGT	WGT

HAS CHILD BEEN UNDER REGULAR SUPERVISION OF A PHYSICIAN (If yes, explain circumstance(s) and current statuses
☐ YES ☐ NO

HAS CHILD BEEN SCREENED FOR ENROLLMENT IN EXCEPTIONAL FAMILY MEMBER PROGRAM ☐ YES ☐ NO

COPY OF IMMUNIZATION RECORD SUBMITTED ☐ YES ☐ NO

DISEASES AND ILLNESSES (CHECK YES OR N0)

CHICKEN POX ☐ YES ☐ NO RUBELLA ☐ YES ☐ NO TEN-DAY MEASLES ☐ YES ☐ NO

MUMPS ☐ YES ☐ NO POLIOMYELITIS ☐ YES ☐ NO SCARLET FEVER ☐ YES ☐ NO

RHEUMATIC FEVER ☐ YES ☐ NO

OTHER (List)

CHRONIC ILLNESS AND CONDITIONS (CHECK YES OR NO)

VISION PROBLEMS ☐YES ☐ NO ASTHMA ☐YES ☐ NO DIABETES ☐ YES ☐ NO

ORTHOPEDIC PROBLEMS ☐ YES ☐ NO AUDITORY PROBLEMS ☐ YES ☐ NO

SEIZURE DISORDER ☐ YES ☐ NO

OTHER (List)

ALLERGIES (List)

COMMENT/INDICATE FREQUENCY

COLDS
EAR ACHES
STOMACH ACHES
HEADACHES
DIARRHEA

COMMENT/INDICATE FREQUENCY
CONSTIPATION
BED WETTING
SLEEP DIFFICULTIES
POOR EATING HABITS
TANTRUMS
EXCESSIVE ACTIVITY

DESCRIPTION OF SERIOUS CHRONIC ILLNESS/CONDITIONS	
ILLNESS/CONDITIONS	DESCRIPTION

ON-GOING MEDICATION			
TYPE	DOSAGE	FREQUENCY	CDP ADMINSTERED

SPECIAL MEDICAL CONSIDERATIONS
DESCRIBE ANY SPECAIL PROGRAM NEEDS, CONSIDERATIONS, OR RESTRICTIONS WHICH THE CHILD REQUIRES, IN ORDER TO PARTICIPATE IN CDP.

MEDICAL STATEMENT
The above named child has been given a routine examination (per age requirements) and is free of infectious or contagious diseases, and is considered to be capable of participating in Child Devlopment Program with the exceptions listed above.

SIGNATURE OF SPONSOR/SPOUSE	DATE
SIGNATURE OF PHYSICIAN & MEDICAL STAMP	**DATE**

CHILDREN YOUTH AND TEEN PROGRAMS
REGISTRATION FORM

Sponsor's Name_____
First/Last

Home Address:_____

City_____ State_____ Zip Code_____

Home #_____Work #_____ Cell #_____

Family Size_____ EMAIL_____

On Base Housing □ □ Off Base Housing
Single Military □ □ Dual Military

Work Unit or Employer_____
Branch:_____ Grade/Rank:_____

FAMILY CARE PLAN REQUIRED FOR DUAL/SINGLE MILITARY AT THE TIME OF REGISTRATION

Due:_____ Signature:_____

Spouse Name:_____
First/Last

Cell Phone_____ Work Phone_____

Work Unit or Employer_____

Work Phone:_____ Grade/Rank_____ Branch_____

Emergency Escort Person's	Home address	Home Number	Work/cell number

Child's Name:_____
Date of Birth_____

Sex:_____ Health Assessment Date:_____
****I will furnish CYTP a Health Assessment within 30 days****

Special
Needs:_____

Allergies:_____

Medication:_____

Program Enrolled: Full time, Hourly, Family child care, School age care
Grade/School_____

Use of photographs for release to media. Yes☐ No ☐

Field trip/walk Yes ☐ No ☐

I, _____parent/guardian of _____ give consent for an authorized CYTP representative to take my child/children for care, medical or dental, in an emergency situation where the child's condition represents a serious or imminent threat to his/her life, health, well being. I understand that a conscientious effort will be made to notify me prior to such action. Camp Lejeune Emergency medial personnel will transport to Naval Hospital when necessary.

Received two CYMS cards on _____, I understand that I have these cards to utilize the Children Youth & Teen Programs. I understand if I lose these cards I will be charged $5.00 per card per child to replace them.

Signature_____
Date_____

For School age children only- The Youth and Teen Programs have access to computers and the Internet. In order for your Youth or Teen to use the computers and the Internet the parent must sign below. The Youth and Teen programs will monitor and block accesses to inappropriate sites, however the parents need to understand that access may be inappropriately obtained.
I give permission for my child_____ to be involved in the usage of computer and Internet
Parent Signature_____

DEPARTMENT OF DEFENSE CHILD DEVELOPMENT PROGRAM
REQUEST FOR CARE RECORD

PRIVACY ACT STATEMENT

AUTHORITY: PL 101-89 Sec. 1507; EO 9397.

PRINCIPAL PURPOSE(S): To collect applicant information for Child Development Programs and place applicants on waiting lists for program services. Information compiled from applications is also used to assist management determination of effectiveness of present and projection of future program requirements.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary; however, failure to furnish requested information will result in an incomplete request for care record and possible loss of placement on Child Development Program waiting lists.

1. DATE OF REQUEST *(YYYYMMDD)*	2. EXPIRATION DATE *(YYYYMMDD)*

3. FAMILY INFORMATION

a. SPONSOR'S NAME *(Last, First, Middle Initial)*	b. SPOUSE'S NAME *(Last, First, Middle Initial)*	
c. CHILD'S NAME *(Last, First, Middle Initial)*	d. CHILD'S DATE OF BIRTH *(YYYYMMDD)*	e. CHILD'S AGE
f. HOME ADDRESS *(Street, City, State, Zip Code)*	g. SPONSOR'S BRANCH OF SERVICE	
	h. DUTY ORGANIZATION	
i. HOME TELEPHONE NUMBER *(Include Area Code)*	j. DUTY TELEPHONE NUMBER *(Include Area Code)*	

k. SIBLING CARE *(Complete a separate form and list name and date of birth for each child requiring care)*

(1) NAME *(Last, First, Middle Initial)*	(2) DATE OF BIRTH *(YYYYMMDD)*	(1) NAME *(Last, First, Middle Initial)*	(2) DATE OF BIRTH *(YYYYMMDD)*

4. PROGRAM(S) DESIRED *(X as applicable)*				5. AGE GROUP *(X one)*	
	a. FULL-DAY CARE		e. FAMILY DAY CARE (FDC)		a. INFANTS *(0 - 12 months)*
	b. PART-DAY CARE		f. PART-DAY ENRICHMENT		b. TODDLERS *(13 - 35 months)*
	c. SCHOOL-AGE		g. DAY CAMP		c. PRESCHOOL *(3 - 5 years)*
	d. SPECIAL NEEDS				d. SCHOOL AGE *(5+ years)*

6. SPONSOR STATUS *(X one)*					
	a. SINGLE MILITARY		e. SINGLE DOD CIVILIAN		i. MILITARY/UNEMPLOYED SPOUSE
	b. DUAL MILITARY		f. RETIRED MILITARY		j. MILITARY/OTHER THAN DOD SPOUSE
	c. MILITARY/DOD SPOUSE		g. MILITARY RESERVE		k. OTHER *(Specify)*
	d. DUAL DOD CIVILIANS		h. NATIONAL GUARD		

7. PRESENT CHILD CARE ARRANGEMENTS *(X as applicable)*					
	a. FDC ON-INSTALLATION		d. CIVILIAN CDC		g. IN-HOME CARE
	b. FDC OFF-INSTALLATION		e. MILITARY ALTERNATE CARE		h. NO PRESENT CARE
	c. OTHER MILITARY CHILD DEVELOPMENT CENTER (CDC)		f. NON-MILITARY ALTERNATE CARE		i. OTHER *(Specify)*

8. GENERAL INFORMATION *(X and complete as applicable)*

YES	NO		YES	NO	
		a. IF CHILD IS NOT PRESENTLY IN CARE, IS EMPLOYMENT OF SPOUSE AWAITED? *(If Yes, estimate average annual income lost)*			c. IS CHILD ON OTHER MILITARY WAITING LIST? *(If Yes, name installation)*
		b. HAS CHILD BEEN IDENTIFIED FOR SPECIAL NEEDS CARE?			d. CURRENT COST OF CARE PER WEEK *(If child is currently in care)*

9. UPDATE REQUIRED PER INSTRUCTIONS *(For Office Use Only)*

	(1)	(2)	(3)	(4)	(5)
a. DATE CALLED *(YYYYMMDD)*					
b. DECLINED/ PLACED					
c. COMMENTS/ INITIALS					
d. PLACEMENT TIME *(In months)*					

Reset

CAMP LEJEUNE CHILDREN YOUTH AND TEEN PROGRAMS
SPECIAL NEEDS SCREENING FORM

Purpose: To provide child and family program eligibility and background information; to assist with child's placement and obtain sponsor consent for access to emergency medical care; data required by EFMP. Policies shall be implemented to ensure that appropriate services are provided for children, youth and teens with special needs. Such policies shall meet the requirement of the Rehabilitation Acts and the Department of Defense Directive 1020.1, Non Discrimination on the Basis of Handicap in Programs and Activities Assisted or Conducted by the Department of Defense.

Routine Uses: This information will be shared with member of the Special Needs Evaluation Review Team (SNERT) to assist with making an informed decision about your child's placement. Information is used for program admission to ensure staff training is pertinent to the child's needs. Information is furnished for the attending physician when it is necessary for a child to be taken to a medical facility by someone other than the parent.

Disclosure: Disclosure of information is voluntary; however, if information is not provided, individuals may not be allowed to participate in Children Youth and Teen Programs. Please note any medication your child may take, or has taken consistently is the last six months.

Child's Name_____ DOB_____ Program_____

Sponsor's Name_____

Exceptional Family Member Program (EFMP) Enrolled (circle) YES/NO

PLEASE CHECK ALL THAT APPLY IF YOUR CHILD HAS BEEN DIAGNOSED WITH ANY OF THE FOLLOWING MEDICAL OR DEVELOPMENTAL CONDITIONS:

___ Allergy (Food or Insect) explain reaction:
_____

___Allergy Seasonal
___Apnea Monitor
___ADD or ADHD
___Asthma or (RAD)
___Autism/Pervasive Developmental Disorder
___Behavior Concerns (ODD,etc)
___Brittle bones
___Cancer
___Cerebral Palsy/Loss of Mobility
___Cleft Lip and/or Palate (Not repaired)
___Cystic Fibrosis
___Developmental delays
___Down Syndrome
___Equipment needs (g-tube, colostomy) 02, tracheotomy, wheelchair, etc.)
___Epilepsy/Seizures
___Genetic Disorders/Congenital Anomalies
___Hearing Impaired
___Heart conditions (congenital or acquired)
___Hydrocephalus/Macrocephaly
___Immune Deficiency
___Inflammatory Bowel Disease (Crohns, UC)
___Psychological Cond (Depression, OCD, etc
___Orthopedic Impairment
___Premature Infant (<35 weeks)
___Spina Bifida
___Speech delay
___Visually Impaired (not corrected by glasses)
___Other_____

Routine Medication(s)_____
Required Special Care or Service(s)_____

___ My child has **NO** special needs or diagnosed condition(s)

_____ _____
Parent Signature Date CYTP Representative Date