On-Site Registration is REQUIRED.
Forms must be dropped off at the Moore Community Center.

DOWN EAST FAMILY YMCA 2020-2021 SCHOOL AGED PROGRAM REGISTRATION FORM

Child's Information:

First Name:_____ MI:_____ Last Name:_____

Gender: F/ M / U Birth Date:____/____/____ Age:____ Grade:____ School Group: Maroon / Gray

Address:_____ City/Town:_____ Zip:_____

Child lives with:_____ Who is responsible for payment?_____

Parent / Guardian Information:

Parent/Guardian #1

Full Name:_____ Birth Date:____/_____/_____

Address:_____ City/Town:_____ Zip:_____

Home Phone:_____ Cell:_____ Work:_____

Place of Employment:_____ N/A ☐

Employer Address:_____

Email Address: | | | | | | | | | | | | | | | | | | | | | | | | |

Parent/Guardian #2

Full Name:_____ Birth Date:____/_____/_____

Address:_____ City/Town:_____ Zip:_____

Home Phone:_____ Cell:_____ Work:_____

Place of Employment:_____ N/A ☐

Employer Address_____

Email Address: | | | | | | | | | | | | | | | | | | | | | | | | |

Emergency Contacts (Must list 3): Please circle Y if allowed to pick up child (photo ID required at pick up).

1. Name:_____ Day Phone:_____ Y / N

Cell:_____ Relationship to Child:_____

2. Name:_____ Day Phone:_____ Y / N

Cell:_____ Relationship to Child:_____

3. Name:_____ Day Phone:_____ Y / N

Cell:_____ Relationship to Child:_____

Parent/Guardian Signature:_____

Care Options: (Please circle all days that apply to your needs)

Before School (6:30-7:30am)

Monday Tuesday Wednesday Thursday Friday

After School (End of school– 5:30pm)

Monday Tuesday Wednesday Thursday Every other Friday

Remote School Aged Care (7:30am– 5:30pm)

Monday Tuesday Wednesday Thursday Every other Friday

Payment Options: ___ Bank Draft (___ Weekly ____ Bi-weekly ___ Monthly) ___ Voucher

Health Information:

Child's Physician:

Name:_____ Phone Number:_____

Address:_____

Child's Dentist:

Name:_____ Phone Number:_____

Address:_____

Health Insurance:

Provider:_____ ID#:_____

Please let us know of any behavioral, medical or allergic conditions your child may have. Please explain any signs or symptoms associated with these conditions. If your child requires an medication, we recommend you speak with your child's physician about having the medication dispensed before or after program hours. N/A ☐

List any illnesses that your child has had or is prone to have that we may need to be aware of. N/A ☐

I authorize the DEFYMCA staff to obtain the following services for my child if necessary: Public Health Nurse, Physician and Ambulance in the event of an emergency (ambulance fees and health cost are the responsibility of the Parent/Guardian). No child will be transported if it is not deemed an emergency.

☐ Please check this box if images of your child may not be used for promotional purposes.

_____

Parent/Guardian Signature Date

Check any or all that may apply:

Does your child have an Individual Education Plan (IEP)? _____YES* ____NO

Does your child have a Behavior Management Plan? _____YES* ____NO

Does your child have a 504 Student Accommodation Form? _____YES* ____NO

If yes was checked for any of the above, an After School Inclusion Form must be completed and returned with your Registration Form. Enrollment will not be considered final until all required forms have been submitted.

Communication with EEMS:

I give permission for the Down East Family YMCA Remote School Age Care program to share information about my child with my child's school.

Guardian Signature:_____ Date:_____

Remote Learning Devices:

You will be required to bring your child's school issued device (iPad, laptop, Ear Buds, Etc) on days they attend full day Remote School Aged Care. Please make sure that your child's device is fully charged as we have a limited number of outlets available for charging. Please provide your child's login information below.

Username:_____ Password:_____

Understanding of How I Can Keep Children and Y Staff Safe

Thank you for working with us to help keep your families, and ours, safe and healthy! Please review the following policies and sign that you understand.

-I must send my child with a mask each day in case social distancing is not possible

-I cannot send my child to Remote School Aged Care if they have a fever (100.4). Temperatures will be taken each day during drop off screening.

-I will inform the Y staff and will not send my child to Remote School Aged Care if my child has experienced any of the following:

-A fever, cough, sore throat, or shortness of breath

-Been in a household with someone who has traveled outside the country in the past month or out of state in the last 14 days.

-Come into contact with anyone who has tested positive for COVID-19

-Been around anyone experiencing signs of illness

Guardian Signature:_____ Date:_____

Walking Permission

There may be times when our staff and participants take a walks around the grounds of the center, around the community, or to a local park or business. Please check the box and sign below to give your child permission to participate in group walks.

☐ I give my child permission to go on walks with DEFY Staff

Guardian Signature: _____ Date: _____

Down East Family YMCA Childcare Bank Draft Form

Contact Information

Parent Name:_____

Child Name:_____

Email Address:_____

Automatic Withdrawal Information

Bank Draft Information (Please check one and attach a voided check)

___Checking Account ____Savings Account

Bank Name_____

Routing/Transit Number (First Set of Numbers) _____

Account Number (Second Set of Numbers)_____

Please continue to "When to Draft"

·OR·

Credit/Debit Card Information

___ Master Card ____ Visa

Card Number _____

Expiration Date _____

When to Draft:

Day of the week to draft:

_____Monday _____Tuesday _____Wednesday _____Thursday _____Friday

How Often?

___Weekly ___Bi-Weekly ___Monthly Draft Start Date:_____

Child Care Payment Policy

I understand that if a payment is returned to the YMCA a $10 charge will be added to my account. The YMCA reserves the right to terminate child care upon non-payment of fees. I understand that I give the YMCA Early Learning Center a 2 week notice of leaving the childcare program or making any changes to the number of days and schedule. An 18% annual interest rate will be assessed to all outstanding balances.

_____ _____

Parent/Guardian Signature Date

Down East Family YMCA

2020-2021 After School Inclusion Form

We believe that parent communication and support is essential to ensure that all children have a fun and successful year at After School Care. Please answer the following questions to help us get to know your child. All information provided will be kept confidential.

Although every effort will be made to provide reasonable accommodations, there may be instances where a child's needs may exceed the scope of our services. We are not able to provide clinical levels of support. We do provide fun experiences in a safe and healthy environment.

Child's Name:_____ Date of Birth:_____

Has your child participated in a DEFYMCA program before? YES NO

If yes, what program?_____

Are there any behavioral concerns that we need to know about to successfully serve your child?

_____

_____

Is there anything that may consistently upset or trigger negative behaviors from your child?

_____

_____

Are there any positive motivators you find work well for your child?

_____

What are some of your child's interests/hobbies?

_____

How does your child interact with peers? Does he/she enjoy participating in group activities?

_____

_____

How does your child interact with authority figures?

_____

How well does your child follow directions? Please explain:

_____

Does your child receive additional support at school?

_____

Is there anything else you would like us to know about your child?

_____

_____

By initialing here, I give the Down East Family YMCA permission to speak with my child's school regarding best practices when working with my child and the services they receive at school. _____

By signing below, I certify that all information provided above is the most current and factual information available.

Parent/Guardian Signature:_____Date ____/____/____

If your child has an IEP, Behavioral Management, or 504 plan please attach a copy to this form.

STATE OF MAINE
DEPARTMENT OF EDUCATION
CHILD NUTRITION
23 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0023

For Use in **CHILD CARE CENTERS**
July 1, 2020 to June 30, 2021

Dear Parent:

The Child Care Center in which you are enrolling your child participates in the U.S. Department of Agriculture's Child and Adult Care Food Program. This means the Center must serve meals and supplements that meet or exceed the nutritional requirements set forth by the U.S. Government.

In return for serving meals and supplements that meet these requirements, the Center receives payment from the USDA based on the income levels of the families being served. The higher the number of children served by the Center who come from low income households, the higher is the level of reimbursement received by the Center for the meals and supplements it serves.

In order to determine the level of reimbursement to be received by the Center for meals or supplements served to your child, USDA requests you to complete the attached application and to include all of the following information on the appropriate lines.

1. The name and age of the child for whom you are making application.

2. If the child for whom you are making application, or any other person in your household, is a member of a Supplemental Nutrition Assistance Program (SNAP) Household (formerly known as Food Stamps), Temporary Assistance to Needy Families (TANF) Assistance Unit or a household that receives benefits under the Food Distribution Program on Indian Reservations (FDPIR), you may give their SNAP, TANF or FDPIR case number in PART I and then skip to PART III.

3. IN PART II you must include the name of each person living in the "household". A "household" is any group of persons living together sharing income and living expenses. These persons may or may not all be related to each other.

4. The last four (4) digits of the Social Security number of the household member or guardian who signs the application form.

5. The total income, before deductions, from all sources, for all persons living in the household.

6. The signature, address, and telephone number of the person completing the application form. The date the form was signed must also be included.

By regulation, if any of the above required information is not included on the application form, the Center has to consider your child to be in that category of eligibility which qualifies it to receive the lowest level of payment for the meals and supplements your child will receive.

The following chart shows the upper income level for the 'Tier I' category for the period **July 1, 2020 to June 30, 2021**. If the total income for your household size is equal to or less than the amount shown, the center serving your child will be able to receive the Tier I, or highest, level of reimbursement for meals or supplements served to your child.

Eligibility Scale for "Reduced-Price" Meals

Family Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	23,606	1,968	984	908	454
2	31,894	2,658	1,329	1,227	614
3	40,182	3,349	1,675	1,546	773
4	48,470	4,040	2,020	1,865	933
5	56,758	4,730	2,365	2,183	1,092
6	65,046	5,421	2,711	2,502	1,251
7	73,334	6,112	3,056	2,821	1,411
8	81,622	6,802	3,401	3,140	1,570
Each Additional Family Member	8,288	691	346	319	160

If a member of your household becomes unemployed, your child may become eligible for "Free" or "Reduced-Price" meals during the period of unemployment, provided the loss of income causes the household income to fall within the eligibility guidelines for your household size.

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 Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (866) 632-9992 (voice) or (800) 877-8339 (TTY) or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

Thank you.

Sincerely,

Staff:
Child and Adult Care Food Program

APPLICATION FOR "FREE" OR "REDUCED-PRICE" MEALS
CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

CHILD FOR WHOM APPLICATION IS BEING MADE: Name:_____ Age: _____

Days of the Week in Care	Hours in Care (i.e. 7:30 – 5:00)	Meals Received While in Care*
☐ Monday		☐ Br ☐ AM S ☐ Lu ☐ PM S ☐ Su ☐ E S
☐ Tuesday		☐ Br ☐ AM S ☐ Lu ☐ PM S ☐ Su ☐ E S
☐ Wednesday		☐ Br ☐ AM S ☐ Lu ☐ PM S ☐ Su ☐ E S
☐ Thursday		☐ Br ☐ AM S ☐ Lu ☐ PM S ☐ Su ☐ E S
☐ Friday		☐ Br ☐ AM S ☐ Lu ☐ PM S ☐ Su ☐ E S
☐ Saturday		☐ Br ☐ AM S ☐ Lu ☐ PM S ☐ Su ☐ E S
☐ Sunday		☐ Br ☐ AM S ☐ Lu ☐ PM S ☐ Su ☐ E S

* Br = Breakfast AM S = AM Snack Lu = Lunch PM S = PM Snack Su = Supper E S = Evening Snack

NOTE: If you are applying for CACFP benefits on behalf of a Foster Child, please check this box and notify the person to whom you return this form. ☐ Foster Child

PART I: HOUSEHOLDS RECEIVING SNAP, TANF OR FDPIR BENEFITS:

If you, your child, or any other person living in your household, currently receives SNAP, TANF or FDPIR benefits, please provide their SNAP, TANF or FDPIR case number. DO NOT COMPLETE Part II; skip to Part III. Part III must include the **printed name** and **signature of the adult who completes this application**. The **date the application was completed** needs to be included also.

(a) ☐ YES: A member of this household receives SNAP, TANF or FDPIR benefits

(b) SNAP Case Number: # _ _ _ _ _ _ _ _ _ _ (**not** EBT number)

(c) TANF Case Number: # _ _ _ _ _ _ _ _ _ _

(d) FDPIR Case Number: # _ _ _ _ _ _ _ _ _ _

If applicable, your child's Free or Reduced-Price meal eligibility information will be disclosed to Medicaid and/or SCHIP unless you elect not to have the information disclosed. The information will be used to identify children eligible for, and to seek to enroll children in, a health insurance program. Your decision on whether to disclose this information will not affect your child's eligibility for Free or Reduced-Price meals.

If you elect not to have this information disclosed to Medicaid and/or SCHIP, please check this box: ☐

NOTE #1:

If no one in your household receives SNAP, TANF or FDPIR benefits, or if you do not provide their case number, you must complete Part II and Part III in order for your child to qualify for either "Free" or "Reduced-Price" meals. **You must also include the last four (4) digits of your Social Security Number on the line next to your signature.**

PART II: ALL OTHER HOUSEHOLDS:

(a) **Household Members**: List the name of every person living in your household. **Be sure to include yourself and the child listed above.**

(b) **Social Security Number**: Section 9 of the National School Lunch Act requires that, unless a SNAP or TANF case number is provided for your child, you must include the last four (4) digits of your Social Security number on the application. This must be the Social Security number of the adult household member signing the application. If the adult household member signing the application does not possess a Social Security number, he/she must indicate so on the application. Provision of a Social Security number is not mandatory, but if the last four (4) digits of the adult household member's Social Security number is not provided or an indication is not made that the adult household member signing the application does not have one, the application cannot be approved. This notice must be brought to the attention of the household member whose Social Security number is disclosed. The Social Security number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the application. These verification efforts may be carried out through program reviews, audits and investigations and may include contacting employers to determine income, contacting a SNAP, Indian Tribal Organization or Welfare Office to determine current certification for receipt of SNAP, FDPIR or TANF benefits, contacting the State Employment Security Office to determine the amount of benefits received and checking the documentation produced by household members to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal action if incorrect information is reported.

(C) **Income**: List **all** income from **all** sources received last month on the same line as the name of the person who received it. Income must be **gross**, that is, it must be the amount received **before deductions** for taxes, Social Security, dues, insurance, etc. List each amount under the correct column. ***If you are in the Military Privatized Housing Initiative or receive combat pay, please do not include these allowances as income.***

LIST ALL HOUSEHOLD MEMBERS:

Names of Household Members:	Age	Monthly Gross Wages or Net Self-Employment	Monthly TANF, Alimony, Welfare, Child Support	Monthly Pensions, SSI, Social Security, Workers Comp, Unemployment Comp, Insurance & Retirement
1.				
2.				
3.				
4.				
5.				
6.				
(Note: Weekly income x 4.333 weeks; Bi-weekly income x 2.15 weeks) **TOTAL MONTHLY HOUSEHOLD INCOME:**				

PART III:

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 Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (866) 632-9992 (voice) or (800) 877-8339 (TTY) or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that all income is reported. I understand this information is being given in connection with the receipt of Federal Funds and Program Officials may verify the information on the application and that deliberate misrepresentation of any of the information on this application may subject me to prosecution under applicable State and Federal Criminal Statutes.

(PRINT NAME OF ADULT)	(LAST 4 DIGITS OF SS#)	(SIGNATURE OF ADULT)	(DATE)
☐ I do not have a social security number			
(HOUSEHOLD ADDRESS OF ADULT)		(HOME PHONE)	(WORK PHONE)

ALL HOUSEHOLDS: Racial/Ethnic Identity: *

1. **Ethnicity:**
   - ☐ Hispanic or Latino
   - ☐ Not Hispanic or Latino

2. **Race (mark one or more):**
   - ☐ American Indian or Alaskan Native
   - ☐ Asian
   - ☐ Black or African American
   - ☐ Native Hawaiian or Other Pacific Islander
   - ☐ White

***This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws. Your response will not affect consideration of your application. If you decline to self-identify your child's race and ethnicity, a visual identification will be made and recorded.**

THIS PORTION MUST BE COMPLETED BY CHILD CARE CENTER PERSONNEL:

Signature: _____ **Date:** _____

Child's Eligibility Category (Circle One): **Free** **Reduced-Price** **Paid**