Summer Vacation at the Y
2025 Registration

Participant Name _____
Birth Date _____ _____

2025 Program Weeks	Summer Vacation at the Y (Ages 5-13) 5-days/week $200 Y Member $240 General Public Jun 30-Jul 2 $125 Y Member $165 General Public
Week 1 June 2-6	No Care Offered
Week 2 June 9-13	❒ New Beginnings
Week 3 June 16-20	❒ Holiday Hits
Week 4 June 23-27	❒ Wonders of Wildlife
Week 5 June 30-July 2 (**No Camp July 3-4**) *See adjusted rate above*	❒ Fantastic 4th
Week 6 July 7-11	❒ Fossil Fun
Week 7 July 14-18	❒ Wild West
Week 8 July 21-25	❒ Green Planet
Week 9 July 28-August 1	❒ Voyage on the High Seas
Week 10 August 4-8	❒ Sports Spectacular
Week 11 Aug 11-15	❒ Super Hero Academy
Week 12 August 18-22	❒ Space Cadets
Week 13 August 25-August 29	❒ Friendly Farewells

Fully complete both sides of the Summer Vacation at the Y Registration form and submit with $30 (per week) deposit. If the requested program is full, your deposit will be returned and you will be placed on a waiting list. Incomplete registrations will not be processed.

A one-time, non-refundable $25 Camp Registration fee is also required. This fee only needs to be paid once, regardless of the number of weeks your camper is registered.

Your child's completed health history profile and immunization information MUST be submitted with this registration form. The registration process will not begin until all completed forms are received. Parents are responsible for any changes to the profile including emergency contact and authorized pick up information.

Balance is due at least (2) two weeks prior to each camp week. An unpaid balance may result in forfeiture of your child's registration. All balances will be auto drafted from the debit/credit card provided for weekly balances. Invoices will not be mailed.

You may be charged a $20 service fee to transfer between weeks or programs.

Approximately one week prior to each camp, you will receive an email with general camp information, arrival and departure times, and a list of things to bring.

We will return all fees except your Registration Fee ($25) and Deposit ($30) if written cancellation is made two weeks prior to each session. After two weeks, refunds will not be available and parents will be held responsible for full balance.

❒ $25 Summer Camp Registration Fee
❒ $30 Deposit (per week) or payment in full

❒ Check Enclosed ❒ Please Charge My: ❒ Visa ❒ MasterCard ❒ Discover Amount: $ _____

*Card #: _____ Exp. Date: _____

Signature: _____ Total Amount Paid Today: $ _____

The card number listed above will be used for all payments at the time they are due.

Send payments and registration paperwork to Stevens Point Area YMCA 1000 Division St. Stevens Point, WI 54481

Summer Vacation at the Y
2025 Registration

Participant Name _____ Birth Date _____ Age _____ Gender _____

Address

_____

_____

School

_____

_____ Grade Next Year _____

Are there any medical, custodial, physical, behavioral conditions or special needs that we should be aware of now?

_____

_____

PARENT/GUARDIAN CONSENT AND WAIVER & RELEASE OF LIABILITY

_____ Initial Section #1: REASONABLE ACCOMMODATIONS CLAUSE: Children with special needs or challenges will be accepted provided that reasonable accommodations can be made for their participation in the program and/or the child's participation does not require an inordinate amount of staff time that would not allow for the safety and welfare of the other children in the program. I understand that if my child requires one-on-one attention, whether due to special needs or behavior, my child may be removed from the program without refund.

_____ Initial Section #2: MEDICAL RELEASE: In the event I cannot be reached, I give consent for YMCA staff to act on my behalf in granting permission for my child to receive emergency treatment. I will be responsible for the payment of all medical services rendered.

_____ Initial Section #3: RELEASE FROM LIABILITY: I understand that all reasonable safety precautions are taken by the YMCA in the operation of its facility, equipment, and programs. However, participants and parents of children must recognize and accept that there are inherent risks when choosing to participate in day camp or any YMCA program; risks that could cause sickness, injury or death. I agree that my child's participation in the YMCA programs shall be undertaken at his/her sole risk, and that the YMCA and Camp Glacier Hollow, its directors, employees, volunteers, and agents shall not be liable for any claims, injuries, damages, losses, diseases, wrongful death, actions or causes of action whatsoever, to my child or his/her property, arising out of or connected to participation in Day Camp including but not limited to transportation services, camping, canoeing/kayaking, hiking, swimming, biking, rock climbing, fishing, horseback riding/grooming, and other camp activities. I agree to hold harmless and indemnify the YMCA and Camp Glacier Hollow, its directors, employees, volunteers, and agents from any and all liabilities and claims resulting from participation in this program.

_____ Initial Section #4: PHOTOGRAPHIC/MEDIA RELEASE: I give my permission for my child to appear in media coverage approved by the YMCA and for the YMCA to use photographs and video of my child for promotional purposes and social media.

_____ Initial Section #5: FIELD TRIP & TRANSPORTATION PERMISSION: I give permission for my child to participate in walking, bus and YMCA Van field trips. I give permission for my child to be transported for field trips or any regularly scheduled vehicle transportation.

_____ Initial Section #6: SUNSCREEN: I give permission for my child to use sunscreen I provide, and for my child to receive application assistance as needed.

_____ Initial Section #7: PARENT HANDBOOK: I have had an opportunity to review the parent handbook and policies of this child care center/day camp and a summary of the WI Rules for Licensing Child Care Centers. I have read the information and agree to abide by the policies and procedures therein.

_____ Initial Section #8: Pets: I have been informed of pets in the center and their degree of contact with my child. I will be informed by the YMCA if pets are added prior to the pet's addition to the center.

_____ Initial Section #9: PARTICIPANT ENROLLMENT ACCEPTANCE: I hereby apply for a reservation for my child as a program participant. I agree to pay the total camp fee on or before the payment due date. Failure to pay by the due date may forfeit my application and deposit. Furthermore, if my child must leave the program due to illness, injury, or inappropriate behavior, a refund may not be available. Children must be picked up from camp by 5:30PM. I understand that an overtime fee of $1 per minute will be charged after 5:30PM, minimum $5 charge. YMCA membership must be valid at the time of registration and maintained through the program dates to receive member rates.

_____ Initial Section #10: ACCURATE/COMPLETE INFORMATION: I hereby state that the information is accurate and complete. I understand that it is my responsibility to provide any changes/updates regarding emergency and health information to the YMCA. I further understand that failure to provide accurate, complete, and updated information may jeopardize my child's registration and/or participation in YMCA programs.

Stevens Point Area YMCA

School Age/Day Camp – Health History and Care Form

FULLY COMPLETE ALL SECTIONS of this REQUIRED Health and Care Form and return to:
Stevens Point Area YMCA, Child Development Office, 1000 Division Street, Stevens Point, WI 54481 (715) 342-2999

First Day of Attendance: _____

Participant Name _____ Birth Date _____ Age _____ ☐ M ☐ F

Street Address _____
Street City State Zip

Home Phone _____ School _____ Grade_____ Height _____ Weight_____

Parent/Guardian Name _____

Home Address _____

City _____ State _____ Zip _____

Place of Employment and Phone # _____

_____

Cell Ph._____ Home Ph. _____

Cell Service Provider (for ER txt) _____

Email Where Reachable While Child is in Care:

_____

Parent/Guardian Name_____

Home Address _____

City _____ State _____ Zip _____

Place of Employment and Phone # _____

_____

Cell Ph._____ Home Ph. _____

Cell Service Provider (for ER txt) _____

Email Where Reachable While Child is in Care:

_____

Please Indicate any Custody Issues _____

Emergency Contacts (other than Parent/Guardian) and Persons Authorized to Pick Up Child.

Emergency Contact Name _____

Relationship to Child _____

Place of Employment and Phone # _____

_____

Cell Ph._____ Home Ph. _____

Cell Service Provider (for ER txt) _____

Email Where Reachable While Child is in Care:

_____

Emergency Contact Name_____

Relationship to Child _____

Place of Employment and Phone # _____

_____

Cell Ph._____ Home Ph. _____

Cell Service Provider (for ER txt) _____

Email Where Reachable While Child is in Care:

_____

Participant Physician _____ Phone _____
Dr. Name/Facility Office Address

Participant Dentist _____ Phone _____
Dr. Name/Facility Office Address

Insurance Information: Is Participant covered by family medical/hospital insurance? ☐ YES ☐ NO

Carrier or Plan Name _____ Member ID # _____ Group # _____

Carrier Address & Phone # _____

Name of Insured _____ Relationship to Participant _____

Emergency Treatment Authorization: In the event I cannot be reached in an emergency, I authorize the YMCA staff to transport to and/or secure from any licensed hospital, physician and/or medical personnel any emergency care or treatment deemed necessary for my child. I agree that I will be responsible for the payment of any and all medical services rendered.

Signature of Parent/Guardian _____ **Date** _____

OVER

Participant Name _____ Birth Date _____ Age _____ ☐ M ☐ F

HEALTH CONDITIONS: (Check any that apply to the participant and explain below, include severity.)

- ☐ Sleepwalking
- ☐ Bed-wetting
- ☐ Athlete's Foot
- ☐ Warts
- ☐ Eating Disorder
- ☐ Diarrhea/Constipation
- ☐ Abnormal Menstruation
- ☐ Homesickness
- ☐ Doesn't Swim (describe)
- ☐ Nightmares
- ☐ Exercise Induced Difficulties
- ☐ Frequent Ear Infections
- ☐ Heart Defect/Disease
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Frequent Headaches
- ☐ Indigestion
- ☐ Sinus Trouble
- ☐ Frequent Nose Bleeds
- ☐ Bleeding Clotting Disorder
- ☐ Fainting/Dizziness
- ☐ Emotional/Behavior Disorder
- ☐ Skin Problems
- ☐ Joint/Bone Problems
- ☐ Head/Neck/Back Injuries
- ☐ Epilepsy/Convulsions/Seizures
- ☐ Visual Impairment/Glasses...
- ☐ Hearing Impairment/Aids...
- ☐ Speech Impairment
- ☐ Learning Disability
- ☐ ADD or ADHD
- ☐ Cognitive Disability
- ☐ Chronic Illness/Condition
- ☐ Cerebral Palsy/Motor
- ☐ Picky Eater
- ☐ Vegetarian
- ☐ Allergies
- ☐ Asthma
- ☐ Other _____
- ☐ Other _____
- ☐ Does participant have a School IEP? If yes please provide a copy.

Give details including triggers, signs/symptoms, care procedures and when to call parent and/or 911 for any conditions checked above: _____

_____

_____

Identify any YMCA staff that you have given specialized instructions/training to: _____

ALLERGIES Describe reaction/symptoms, management instructions and when to call parent or 911.

Medications (list)

_____ _____

_____ _____

Foods (list)

_____ _____

_____ _____

Insects, Animals, Plants...

_____ _____

_____ _____

MEDICATIONS

Will participant medication need to be taken during this program? ☐ Yes ☐ No ☐ Maybe *If yes or maybe, a* Authorization to Administer Medication form must be completed (Attached to this packet). All Medications are required to be in original containers and be clearly labeled.

List and describe any other participant Health Conditions/Disorders/Impairments/Diseases/Illnesses/Major Surgeries/ Special Needs and indicate if there are any Restrictions: _____

_____

_____

*** A copy of participant's immunization records or provided form must be attached.**

I hereby state that the information I have provided is accurate and complete. I understand that it is my responsibility to provide any changes/updates regarding emergency and health information to the YMCA. I further understand that failure to provide accurate, complete, and updated information may jeopardize my child's participation in this program.

_____ _____ _____

Participant Name - Please Print | Signature of Parent/Guardian | Date

Review dates: _____ _____ _____ _____ _____

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44192 (02/2023)

STATE OF WISCONSIN
Wis. Stat. § 252.04

CHILD CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO CHILD CARE CENTER. State law requires all children in child care centers to present evidence of immunization against certain diseases within **30 school days (6 calendar weeks) of admission to the child care center.** These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the child care center. See "Waivers" below. If you have any questions about immunizations, or how to complete this form, please contact your child's child care provider or your local health department.

STEP 1 PERSONAL DATA PLEASE PRINT

Child's Name(Last, First, Middle Initial)	Date of Birth (Month/Day/Year)	Area Code/Telephone Number
Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)	Address (Street, Apartment number, City, State, Zip)	

STEP 2 IMMUNIZATION HISTORY

List the MONTH, DAY AND YEAR the child received each of the following immunizations. If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the records.

TYPE OF VACCINE	First Dose Month/Day/Year	Second Dose Month/Day/Year	Third Dose Month/Day/Year	Fourth Dose Month/Day/Year	Fifth Dose Month/Day/Year
Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP, or DT)					
Polio					
Hib (Haemophilus *Influenzae* Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (Chickenpox)					

History of Varicella/Chickenpox

In accordance with DHS 144.03(2)(g), I attest that this child has a reliable history of varicella disease and is not required to receive Varicella vaccine.

_____ _____

SIGNATURE – Physician/PA/APNP Date Signed

STEP 3 REQUIREMENTS

The following are the minimum **required** immunizations for the child's age/grade at entry. All children within the range must meet these requirements at child care entrance. Children who reach a new age/grade level while attending this child care must have their records updated with dates of additional required doses.

AGE LEVELS	NUMBER OF DOSES						
5 months through 15 months	2 DTP/DTaP/DT	2 Polio	2 Hib	2 PCV	2 Hep B		
16 months through 23 months	3 DTP/DTaP/DT	2 Polio	3 Hib[1]	3 PCV[2]	2 Hep B	1 MMR[3]	
2 years through 4 years	4 DTP/DTaP/DT	3 Polio	3 Hib[1]	3 PCV[2]	3 Hep B	1 MMR[3]	1 Varicella
At Kindergarten entrance	4 DTP/DTaP/DT[4]	4 Polio			3 Hep B	2 MMR[3]	2 Varicella

[1]If the child began the Hib series at 12-14 months of age, only two doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age (Note: a dose four days or less before the first birthday is also acceptable).

[2]If the child began the PCV series at 12-23 months of age, only two doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required.

[3]MMR vaccine must have been received on or after the first birthday (Note: a dose four days or less before the first birthday is also acceptable).

[4]Children entering kindergarten must have received one dose after the fourth birthday (either the third, fourth or fifth) to be compliant (Note: a dose 4 days or less before the fourth birthday is also acceptable).

STEP 4 COMPLIANCE DATA AND WAIVERS

IF THE CHILD MEETS ALL REQUIREMENTS (sign at STEP 5 and return this form to the child care center), OR

IF THE CHILD **DOES NOT** MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to child care center).

☐ Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received. I, understand that it is my responsibility to obtain the remaining required doses of vaccines for this child **WITHIN ONE YEAR** and to notify the child care center in writing as each dose is received.

NOTE: Failure to stay on schedule or report immunizations to the child care center may result in court action against the parents and a fine of $25.00 per day of violation.

☐ For health reasons this child should not receive the following immunizations _____(List in STEP 2 any immunizations already received)

_____
Physician's Signature Required

☐ For religious reasons this child should not be immunized. (List in STEP 2 any immunizations already received)

☐ For personal conviction reasons this child should not be immunized. (List in STEP 2 any immunizations already received):

STEP 5 SIGNATURE

To the best of my knowledge, this form is complete and accurate.

_____ _____

SIGNATURE - Parent, Guardian or Legal Custodian Date Signed

CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
HOUSEHOLD LETTER (Non-Pricing Programs)

For Group Child Care & Outside of School Hours Centers
FFY 2026, Rev. 6/25

Dear Parent or Guardian:

Stevens Point Area YMCA / Glacier Hollow is enrolled in the CACFP, a USDA program which
(Name of Agency)
provides federal assistance dollars to eligible child care centers for serving more nutritious meals. The amount of money our agency receives from this program is based on the income levels of our families. **In order to continue providing a quality meal service without additional charge, we request every family of our enrolled children to complete new a Household Size-Income Statement form (HSIS) each year. Please complete and return the attached HSIS form to our office. This information will be kept strictly confidential in our files.** Only one completed HSIS is required for all children in your household. Once we have properly approved your HSIS as eligible, our agency will receive the higher *("Free" or "Reduced-price")* meal reimbursement rates for your enrolled children, for 12 months from the *Effective Month of Determination* regardless of any change in your household size and/or income or termination from Benefits Programs.

- You are not required to complete this HSIS if no one in your household receives benefits from FoodShare (Supplemental Nutrition Assistance Program (SNAP)), FDPIR (Food Distribution Program on Indian Reservations), Wisconsin Works Programs and your household income is higher than the amount shown for your household size within the table below. In this case, however, we would appreciate you returning the HSIS to us with "N/A" written on it along with your signature and date.

Determining Eligibility based on Participation in Benefits Programs → *Complete Part 1 and Part 3 of HSIS form*

Our agency receives the Free meal reimbursement rate for children in households receiving benefits from FoodShare WI, FDPIR, or Wisconsin Works (W-2) Programs. W-2 Programs is Wisconsin's Temporary Assistance for Needy Families (TANF) program. It provides employment preparation services, case management, and cash assistance to eligible families with the following programs: Trial Employment Match Program (TEMP), Community Service Jobs (CSJ), Case Management, W-2 Transitions (W-2T), Custodial Parent of an Infant (CMC), and At-Risk Pregnancy (ARP). **W-2 Programs IS NOT the WI Child Care Subsidy Program.**

You must include the following information on the HSIS (a-c) for eligibility based on receiving benefits from FoodShare, FDPIR, W-2 Works Programs:

(a) The names of your enrolled children;
(b) Checked box for the benefit your household receives and its case number; &
(c) The signature of an adult member in the household & signature date

- DO NOT list case numbers for:
- Medicaid, SSI, OR Wisconsin Child Care Subsidy program AND
- DO NOT list 16-digit Quest Card number *(starts with 5077)* for FoodShare

Determining Eligibility by Household Size and Income → *Complete Part 2 and Part 3 of HSIS form*

Household-Size Income Scale (Effective July 1, 2025 to June 30, 2026)

Household Size	Annual Income Level (at or below)
1	$ 28,953
2	$ 39,128
3	$ 49,303
4	$ 59,478
5	$ 69,653
6	$ 79,828
7	$ 90,003
8	$ 100,178
For each additional Household Member, add:	+$ 10,175

If your household earns a total income that is less than or equal to the income levels listed within this table, we will receive higher meal reimbursement rates *("Free" or "Reduced-price" meal rate)* for your children. **For determining eligibility based on your household size and income, you must include the following information on the HSIS (a-e):**

(a) Full names of all household members who share income and expenses, including children, parents, and non-related persons;
(b) Income received by each household member identified by source of income and its pay frequency;
(c) Total number of household members;
(d) The signature of an adult member of the household and signature date; and
(e) The last four digits of the social security number of the adult household member signing the HSIS or an indication he/she does not have a social security number.

- Disclosure of United States citizenship or immigration status is not required and is not a condition of eligibility for higher meal reimbursement rates.

Eligibilities of Foster, Runaway, Homeless, and Migrant Children, and Children enrolled in Head Start: Our agency will receive the Free meal reimbursement rates for foster, runaway, homeless, and migrant children and children enrolled in Head Start who reside in your household, when you provide the respective documentation listed below. **The respective documentation is required for these children to be eligible for Free Meals: These children's eligibility for Free meals does not extend to other children in your household.**

- **Foster children:** Your completed HSIS with the 'Foster Child' box checked next to your foster children's names. When including them on your HSIS completed for your non-foster children, any income reported for your foster children must only be for their personal use. Your foster children will then be eligible at the "Free" meal rate. Your non-foster children's eligibilities will be based on the benefits or income information provided on your household's completed HSIS form.
- **Children Enrolled In Head Start:** Written certification of your child's Head Start enrollment eligibility period from the Head Start administering agency.
- **Runaway, Homeless, and Migrant Children:** Written certification of the child's status from an official of the appropriate Runaway and Homeless Youth Program, Migrant Education Program, or school official.

Use of Information Statement: The Richard B. Russell National School Lunch Act requires the information on this form. You are not required to provide this information, but if you do not, our agency cannot receive higher reimbursement rates for meals served to your children. You must include the last four digits of the social security number of the household member signing the form unless: the HSIS is only for your foster child(ren); you list a case number for receiving benefits from FoodShare WI, WI Works Cash Programs, or FDPIR; or when the household member signing the HSIS checks "None" for not having a SS#.

Sharing Eligibility Information: Children's eligibility information may be shared in accordance with disclosure protection requirements without prior notification, with education, health, and nutrition programs to assess their eligibility for benefits. The law allows us to share your children's eligibility information with programs such as Medicaid or BadgerCare for ensuring their access to free or low cost health insurance, **unless you tell us not to.** This information may only be used for determining eligibility for their programs; if your children are eligible, they may contact you to offer their enrollment options. Filling out this HSIS does not automatically enroll your children in these programs. **If you do not want your information to be shared with these programs, notify us in writing. This notification will not change whether your children's meals are eligible for meal reimbursement.** Your eligibility information provided on the HSIS may also be shared with auditors for program reviews and law enforcement officials for the purpose of investigating violations of program rules.

Refer to the USDA Non-Discrimination Statement and Complaint Filing Procedure (https://dpi.wi.gov/nutrition#discrimination).
This institution is an equal opportunity provider.

Julie Trone
Signature of Agency Representative

CACFP ENROLLMENT FORM

Child Care Name:

Parent/Guardian Instructions:
This form can be used for up to three children per household. In the spaces below list the child's name, current age, the days and hours normally in care, and the meals normally received while in care. If the child is of school age report the hours in care both before and after school. Child and Adult Care Food Program (CACFP) regulations require that the enrollment form be updated annually and signed by the child's parent or guardian. **This form can be used for three years for the same child(ren), to meet the annual updating requirements.**

HOURS AND MEALS WHILE IN CARE

						Meals Normally Received While in Care (Check ✓)					
Child's Name:	**Days Normally in Care (Check ✓)**	**From**	**To**	**From**	**To**	**Breakfast**	**AM Snack**	**Lunch**	**PM Snack**	**Supper**	**Evening Snack**
	☐ Sunday					☐	☐	☐	☐	☐	☐
	☐ Monday					☐	☐	☐	☐	☐	☐
	☐ Tuesday					☐	☐	☐	☐	☐	☐
Date of Birth:	☐ Wednesday					☐	☐	☐	☐	☐	☐
	☐ Thursday					☐	☐	☐	☐	☐	☐
	☐ Friday					☐	☐	☐	☐	☐	☐
	☐ Saturday					☐	☐	☐	☐	☐	☐

Additional Information (Year One):	**Additional Information (Year Two):**	**Additional Information (Year Three):**

HOURS AND MEALS WHILE IN CARE

						Meals Normally Received While in Care (Check ✓)					
Child's Name:	**Days Normally in Care (Check ✓)**	**From**	**To**	**From**	**To**	**Breakfast**	**AM Snack**	**Lunch**	**PM Snack**	**Supper**	**Evening Snack**
	☐ Sunday					☐	☐	☐	☐	☐	☐
	☐ Monday					☐	☐	☐	☐	☐	☐
	☐ Tuesday					☐	☐	☐	☐	☐	☐
Date of Birth:	☐ Wednesday					☐	☐	☐	☐	☐	☐
	☐ Thursday					☐	☐	☐	☐	☐	☐
	☐ Friday					☐	☐	☐	☐	☐	☐
	☐ Saturday					☐	☐	☐	☐	☐	☐

Additional Information (Year One):	**Additional Information (Year Two):**	**Additional Information (Year Three):**

HOURS AND MEALS WHILE IN CARE

						Meals Normally Received While in Care (Check ✓)					
Child's Name:	**Days Normally in Care (Check ✓)**	**From**	**To**	**From**	**To**	**Breakfast**	**AM Snack**	**Lunch**	**PM Snack**	**Supper**	**Evening Snack**
	☐ Sunday					☐	☐	☐	☐	☐	☐
	☐ Monday					☐	☐	☐	☐	☐	☐
	☐ Tuesday					☐	☐	☐	☐	☐	☐
Date of Birth:	☐ Wednesday					☐	☐	☐	☐	☐	☐
	☐ Thursday					☐	☐	☐	☐	☐	☐
	☐ Friday					☐	☐	☐	☐	☐	☐
	☐ Saturday					☐	☐	☐	☐	☐	☐

Additional Information (Year One):	**Additional Information (Year Two):**	**Additional Information (Year Three):**

PARENT/GUARDIAN SIGNATURE

Parent/Guardian Signature (Year One):	Date *Mo./Day/Yr.*	*Parent/Guardian Initials (Year Two):*	Date *Mo./Day/Yr.*	*Parent/Guardian Initials (Year Three):*	Date *Mo./Day/Yr.*

HOUSEHOLDSIZE—INCOMESTATEMENT

ChildandAdultCareFood Program

An adult household member mustcompletethisform(HSIS)andreturnittothe center.Complete one HSIS per household.
Refer to the accompanying *Household Letter* for instructions on completing this form.

First and Last Name(s) of Enrolled Child(ren):	**Center**

PART 1: BENEFITS

Do any household members currentlyparticipatein FoodShareWI, WI Works Programs, or FDPIR?
If yes, check the program and write the corresponding case number below; then go to Part 3. If no, skip to Part 2.

☐ **FoodShareWisconsin(10-digitcasenumber):**
DO NOT list a 16-digit Quest Card number or number that starts with 5077.
____

☐ **FDPIR (9-digit case number):**
____

☐ **WisconsinWorksPrograms(10-digitcasenumber):**
DO NOT provide a WI Childcare Subsidy number. This is NOT a WI Works Program and does not qualify a child as free in CACFP.
____

PART2: HOUSEHOLDSIZEANDINCOME

If you did not complete PART 1, completea,b, and c below; thengoto PART 3.

a) Household Members Information:
List full names of all members in first column, including yourself andallchildren.

b) List all incomeon the sameline as theperson who receives it.
- Record eachincome source onlyonce.
- Check the box for how often eachincome source is received.

Household Member Names **Household Member:** anyone who is living with you and shares income and expenses, even if not related.	(Optional) **Age**	**Check if Foster Child**	**Check if No Income**	Gross wages, Net income (self-employed), Tips, Commission, Cash bonuses, Military pay & allowances, Work comp, Unemployment	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually	Retirement, Social Security, SSI, Disability, VA benefits, Child Support, Alimony	Weekly	Twice per Month	Every 2 Weeks	Monthly	Annually	Private pensions, Trusts, Annuities, Investments, Interest, Net rental income, Savings withdrawals, Any other income	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐

c) Record total # of household members: ______

PART 3: SIGNATURE

An adult household member must sign and date this form
If PART 2 is completed, the adult signing the form **must list the last four digits of their SS#** OR check "None" if they do not have a SS#.

ETHNICITY ANDRACE DATACOLLECTION–*Completion isoptional*
This center is required by Federal law to ask the following two questions concerning ethnicity and race. Your answers are strictly for statistical reporting and will have no effect on determination of eligibility for benefits. **Please answer both questions.**

IS YOUR CHILD(REN) HISPANIC OR LATINO? ☐ Yes, Hispanic or Latino ☐ No, neither Hispanic nor Latino

SELECT ONE OR MORE OF THE FOLLOWING CATEGORIES THAT APPLY TO YOUR CHILD(REN):
☐ American Indianor AlaskaNative ☐ Black orAfrican American ☐ White ☐ Asian ☐ NativeHawaiianorOtherPacificIslander

I CERTIFY that all information on this form is true. I understand that this information is given in connection with the receipt of Federal funds and that CACFP officials may verify the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws.

Signature of Adult Household Member	**Signature Date** *Mo./Day/Yr.*	**Last4digitsofSS#**(orcheck "None" if you donothaveaSS#) ***-**-_______ _______ ☐ **None**

FOR CENTER USE ONLY – Complete all 3 sections

Section 1: Basis of Determining Eligibility *(A or B)*		**Section 2: Eligibility Determination**	**Section 3: Determining Official's Initials/Approval Date Effective Month of Determination**
A. Household Size & Income **Total Household Size** __________ ***Total Income $**\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ ($ Amount) (Time Period)	***B. Benefits/Foster*** ☐ **FoodShare WI** ☐ **W-2 Programs** ☐ **FDPIR** ☐ **Foster Child(ren)**	☐ **Free** ☐ **Reduced** ☐ **Non-Needy**	**Initials/Date:** ____________________________ ****Effective Month of Determination:** ________________________ **Month/Year**

*Converttoyearlyincome only when multiplepay frequencies are reported, using only these multipliers:	Weekly x52 Every 2 weeks x 26	Twicea monthx24 Monthly x 12	**Thisform expires oneyearfromthe *Effective Month of Determination.*

This institution is an equal opportunity provider.