YWCA Early Learning Center Enrollment Form

Center: ____________________________ Date: ____________

Thank you for choosing a YWCA facility for your child care needs. This form will serve as your agreement with the YWCA for the children named below.

<table>
<thead>
<tr>
<th>Child's name</th>
<th>Date of Birth</th>
<th>Target Class</th>
<th>Starting Date</th>
<th>Weekly or Daily Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
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<tr>
<td>3.</td>
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<tr>
<td>4.</td>
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</tr>
</tbody>
</table>

Membership Fee: ______________________ Total(weekly/daily)Fee: ______________________

Payments must be paid at least weekly (due Mondays or on the first open day of the week).

No credit is given for absences due to any reason (including illness, vacation, and holidays). Parents must notify the center office for any absence. In order to receive a refund, two weeks written notice is required. At the time the written notice is received the child will be withdrawn.

The YWCA’s early learning center program has been discussed with me and I agree to the following:

1. It is the responsibility of the parent to contact the center when the child/children will be absent.
2. Parent will pay a late pick-up charge of $5 per child for every 15 minutes (or portion thereof) after the center closes at 6:30 p.m. If by 7:00 p.m. no contact to the center by the parent has been made, the child will be placed in the custody of the Texas Department of Family and Protective Services. Children may be dropped from the program if full payment is not made by the first open day of the week.
3. Parent is responsible for full amount if fee is subsidized and contract is terminated or parent fails to recertify.
4. The YWCA will not assume responsibility for any child who has not been signed in for child care when she/he arrives for the day or for any child who has been signed out for the day from any child care program.

The term “parent” shall include only those with custody of the respective child, or those designated by the court as managing conservators and/or legal guardians. The undersigned parent and her/his respective spouse if not joint herein, agree to identify, defend and hold the YWCA harmless for and against any and all liabilities, claims, causes of action or expenses, including attorney’s fees which may result from the inadvertent or forced release of a child to any person not specifically authorized or approved to call for said child, as listed above.

Parent’s Signature: ____________________________ Printed Name: ____________________________

YWCA Rep. Signature: ____________________________ Date: ________________
# YWCA ADMISSION INFORMATION

**Operation Name:**

**Director's Name:**

**Child's Name:**

**Date of Birth:**

**Child's Home Address:**

**City:**

**State:**

**Zip Code:**

**Date of Admission:**

**Date of Withdrawal:**

**Child's Home Telephone Number:**

**Parents/Guardians' Name:**

**First:**

**Last:**

**Mi:**

**I acknowledge receipt of the YWCA Child Care Operational Procedures:**

**Parent/Guardian Address (if different from child):**

**Street:**

**City:**

**State:**

**Zip Code:**

**Phone Numbers Where Parents May Be Reached:**

**Mother's Work:**

**Mother's Home:**

**Father's Work:**

**Father's Home:**

**Guardian's Work:**

**Guardian's Home:**

**Name, Address & Phone Number of Emergency Contacts My Child May Be Released to if I Cannot Be Reached:**

**Name & Address:**

**Number:**

**Name & Address:**

**Number:**

**I agree/ I do not give consent for my child to be transported when supervised by the center's employees for:**

- [ ] Emergency Care
- [ ] Field Trips
- [ ] To & From School

**Parent Comments:**

**I agree/ I do not give consent for my child to participate in Water Activities including:**

- [ ] Swimming Pools
- [ ] Splashing/Wading Pools
- [ ] Sprinklers
- [ ] Water Table Play

**I agree/ I do not give permission my child to participate in Evaluation (Health & Developmental) and in Videotaping and Pictures connected with the YWCA.**

**I hereby, for myself and my child, waive and release all rights and claims for damages I may have against the YWCA, directors or staff for any injuries suffered by my child as a participant in any YWCA program, except those arising out of gross negligence or intentional acts.**

**Authorization for Emergency Medical Attention:**

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to secure any and all necessary medical care for my child.

**Name, Address & Number of my Child's Physician:**

**Number:**

**Immunizations: All immunizations are due to the center no later than five attendance days after enrollment.**

**Immunization Card:**

- [ ] Pending
- [ ] In File

**List any special problems that your child may have, such as allergies, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information which caregivers should be aware of:**

**School Age Children:** My child attends the following school:

**School Phone Number:**

**My child has permission to:**

- [ ] Ride a Bus
- [ ] Walk to and From School
- [ ] Be released to the care of his/her sibling(s) under 18 years old (with photo ID)

**Admission Requirements:**

If your child does not attend pre-kindergarten or school away from the center, one of the following must be presented when your child is admitted to the center:

1. [ ] Health Care Professional's Statement: I have examined the above named child within the past year and find that he/she is physically able to take part in the day care program.

   **Health Care Professional's Signature:**

   **Date:**

2. [ ] A signed and dated copy of the health care professional's statement is attached.

3. [ ] Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of, I have attached a signed and dated affidavit stating this.

4. [ ] My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and will submit it to the day care program.

**Vision:**

<table>
<thead>
<tr>
<th>R 20/</th>
<th>L 20/</th>
<th>Pass</th>
<th>Fail</th>
</tr>
</thead>
</table>

**Hearing:**

<table>
<thead>
<tr>
<th>1000 Hz</th>
<th>2000 Hz</th>
<th>4000 Hz</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right</td>
<td>Pass</td>
<td>Fail</td>
</tr>
<tr>
<td>Left</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Signature:**

**Date:**

**PARENT SIGNATURE:**

**DATE:**
By signing this form, I hereby authorize YWCA El Paso del Norte Region to publish photographs taken of me, my name and likeness, for use in YWCA El Paso del Norte's print, online and video-based marketing materials, as well as other Company publications.

Release of Liability: I am willingly and voluntarily participating in the activities offered by YWCA El Paso del Norte Region (YWCA), I, the undersigned hereby release YWCA, their principals, agents, employees, and volunteers from any and all liability, claims, demands, actions or right of action, which are related to, arise out of, or are in any way connected with my participation in this activity, including those allegedly attributed to the negligent acts or omissions of the above mentioned parties. If I am signing on behalf of a minor child as Parent/Guardian, I also give full permission for any person connected with YWCA El Paso del Norte Region to administer first aid deemed necessary, and in case of serious illness or injury, I give permission to call for medical and/or surgical care for the child and to transport the child to a medical facility deemed necessary for the well being of the child.

The YWCA applies for grants and contributions as part of our efforts to keep program fees affordable. Many such applications require the YWCA to state demographics about the individuals we serve. Please help us by checking the appropriate boxes below so you can be counted. Demographic information is used/reported ONLY in aggregate and is not tied to individual members.

How did you hear about YWCA?
- Friend or family member
- Social Media
- Online Advertisement
- Television Advertisement
- Radio Commercial
- Magazine Ad
- Newspaper Ad
- Other: ______________
- Kiddos Magazine

Employer or College attending?
- EPCC
- UTEP
- SISD
- EPISD
- Clint ISD
- Canutillo ISD
- Other
- Student
- Faculty or Staff
- N/A

Ethnicity/Race of Household Members (Check all that apply)
- Hispanic or Latino
- African-American or Black
- Caucasian or White
- Native American or American Indian
- Asian or Pacific Islander
- Multi-ethnic or Multi-racial

Household Income:
- $0 - $18,999
- $19,000 - $29,999
- $30,000 - $39,999
- $40,000 - $49,999
- $50,000 and over

By signing this form, I hereby authorize YWCA El Paso del Norte Region to publish photographs taken of me, my name and likeness, for use in YWCA El Paso del Norte's print, online and video-based marketing materials, as well as other Company publications.

Release of Liability: I am willingly and voluntarily participating in the activities offered by YWCA El Paso del Norte Region (YWCA), I, the undersigned hereby release YWCA, their principals, agents, employees, and volunteers from any and all liability, claims, demands, actions or right of action, which are related to, arise out of, or are in any way connected with my participation in this activity, including those allegedly attributed to the negligent acts or omissions of the above mentioned parties. If I am signing on behalf of a minor child as Parent/Guardian, I also give full permission for any person connected with YWCA El Paso del Norte Region to administer first aid deemed necessary, and in case of serious illness or injury, I give permission to call for medical and/or surgical care for the child and to transport the child to a medical facility deemed necessary for the well being of the child.

Signature of participant: __________________________ Date: __________

-------------------------- If the participant is under the age of 18 --------------------------

Signature of Parent/Guardian: __________________________ Print Name: __________________________ Date: __________
I would like to receive text messages to my mobile telephone number from YWCA.
I understand that the content may relate to any aspect of the branch including: pool closures, important over-all agency updates, new class information, emergencies, etc. Text messages will be limited to two per month aside from emergency communications.

Should I wish to withdraw from the text messaging service, I understand that I need to either provide either a written notice to the Customer Service Staff at the Branch or follow the opt out instructions from the text messaging provider. Once you opt out the same phone number and e-mail cannot be re-entered.

I will advise the Customer Service Staff at the Branch if I change my mobile number and I understand that a new consent form will be required.

I am aware that I am responsible for text messaging fees associated with the incoming text messaging sent by the YWCA. I also understand that the YWCA will not share my personal cell phone number with any third party organizations.

Please check all that apply:

- ☐ YWCA STAFF
- ☐ EARLY LEARNING ACADEMY
- ☐ HEALTH & WELLNESS
- ☐ AFTER SCHOOL PROGRAM

TEXT MESSAGES

☐ I would like to receive text messages to my mobile telephone number from YWCA.

EMAIL

☐ Yes, I would also like to receive updates about the YWCA via email.

☐ No, I would not like to receive updates about the YWCA via email.

I confirm and agree to the above statements.

Print full name: ____________________________________________________________

Signature: ___________________________ Date: _________________________________
YWCA CHILD CARE POLICY

Behavioral Expectations

Children participating in any YWCA child care program, including day care centers, after-school programs, summer camp, and fun days, are expected to behave in an age-appropriate manner, respectful of themselves and others, and in a pattern that promotes a positive and safe environment for all. Normal and expected standards include, but are not limited to:

- Respect for teachers, recreation staff, and other adults who are responsible for the safety and well-being of all of the children;
- Respect and appropriate interactions with peers and other children participating in the YWCA program, demonstrating tolerance for and appreciation of individual differences, and resolving conflict using non-aggressive methods;
- Respect for physical property, regardless of owner.

Children are free to discuss any specific rules with their teachers or recreation leaders.

Should a child choose not to adhere to these basic standards, the following steps will be taken:

1) The child will be removed from any situation that may result in an unsafe environment,
2) The adult supervisor may explain why the child is being separated from the other children and engage in a discussion with the child; the discussion will not include yelling, inappropriate language, or other disrespectful behavior;
3) The child may be asked to play or work separately from other children if deemed necessary or advisable by the adult supervisor.

If the inappropriate behavior is isolated, the child may be allowed to rejoin the group if the adult supervisor has reason to believe that the behavior will not be repeated. Should the inappropriate behavior be repeated, the child will remain separate from the other children and the child’s parent or guardian will be contacted.

If, despite the efforts of parents and adult supervisor, the child’s behavior continues to jeopardize either his or her own safety and well being, or that of any other person involved with the YWCA program, the following options are available:

1) The child will be suspended from the program for one week. If, upon return, the behavior continues to jeopardize his or herself or other children, the child will be permanently dismissed from the program.
2) The child may return to the program only if the legal parent or guardian is in attendance at all times, for a period of three days. If the child’s behavior improves so that his or her behavior no longer jeopardizes the safety and well being of his or her self and/or the other participants, the child may continue to attend without the parent or guardian in attendance. If, in the opinion of the adult supervisor, the child’s behavior is not considered to be appropriate, the child will be dismissed from the program. Every effort will be made to provide parents with a one-week notification of this action.

The child’s legal parent or guardian may request a meeting with the Child Development Center Director, Director of School Age and/or the Program Director. Please refer to the Operational Procedures provided to you at the time of enrollment for additional information.

I have read, understood, and agree to the policy stated above:

_________________________  _________________________
Name or parent/guardian     Signature of parent/guardian

_________________________  _________________________
Date                      Signature of YWCA representative
Discipline and Guidance Policy for

Price

◆ Discipline must be:
  (1) Individualized and consistent for each child;
  (2) Appropriate to the child’s level of understanding; and
  (3) Directed toward teaching the child acceptable behavior and self-control.

◆ A caregiver may only use positive methods of discipline and guidance that encourage self-esteem, self-control, and self-direction, which include at least the following:
  (1) Using praise and encouragement of good behavior instead of focusing only upon unacceptable behavior;
  (2) Reminding a child of behavior expectations daily by using clear, positive statements;
  (3) Redirecting behavior using positive statements; and
  (4) Using brief supervised separation or time out from the group, when appropriate for the child’s age and development, which is limited to no more than one minute per year of the child’s age.

◆ There must be no harsh, cruel, or unusual treatment of any child. The following types of discipline and guidance are prohibited:
  (1) Corporal punishment or threats of corporal punishment;
  (2) Punishment associated with food, naps, or toilet training;
  (3) Pinching, shaking, or biting a child;
  (4) Hitting a child with a hand or instrument;
  (5) Putting anything in or on a child’s mouth;
  (6) Humiliating, ridiculing, rejecting, or yelling at a child;
  (7) Subjecting a child to harsh, abusive, or profane language;
  (8) Placing a child in a locked or dark room, bathroom, or closet with the door closed; and
  (9) Requiring a child to remain silent or inactive for inappropriately long periods of time for the child’s age.

Texas Administrative Code, Title 40, Chapters 746 and 747, Subchapters 1, Discipline and Guidance

My signature verifies I have read and received a copy of this discipline and guidance policy.

Signature

Date

Check one please:

☐ parent    ☐ employee/caregiver    ☐ household member of child-care home

TDPRS-CCL 06/02/03
Dear Parent,

The following outlines our policy pertaining to infant sleep for babies under our care.

ALL infants under 12 months will be placed for sleep using these guidelines.

- The infant shall be placed on their back on a firm, tight-fitting mattress in a crib or bassinet.
- Waterbeds, sofas, soft mattresses, pillows, bean bag chairs, and other soft surfaces shall be prohibited as infant sleeping surfaces.
- All pillows, quilts, comforters, sheepskins, stuffed toys, and other soft products shall be removed from the crib during baby’s sleep.
- The infant’s head shall remain uncovered during sleep.
- When infants can easily turn over from the back to the stomach position, they shall be put down on their backs and re-turned, as position change is noted.
- Unless a doctor prescribes a positioning device that restricts movement within the child’s crib, such devices shall not be used.

It is important that you and others who care for your baby practice back sleeping when your child is in your care. Babies who are accustomed to sleeping on their backs and who are placed on their stomachs to sleep have increased SIDS risk during periods while they are on their stomachs.
I, the undersigned, as the parent/guardian of ________________

Have read and understand the infant sleep policy. I agree and have designated below one of the following sleep positions for my infant from birth-12 months of age when receiving care at the YWCA ________________ Early Learning Center.

A. ___ My infant will be placed on his/her back to sleep as recommended by the American Academy of Pediatrics.

B. ___ My infant has a special medical condition. After considering the risks and benefits, my child’s physician has provided written instructions to place my infant to sleep on his/her stomach. These instructions, signed by a physician, are attached to this Infant Sleep Position Agreement.

__________________________________________
Parent/Legal Guardian Signature

________________________
Date

__________________________________________
Parent/Legal Guardian Printed Name

__________________________________________
Address

__________________________________________
Home Phone Number

__________________________________________
Work Phone Number

__________________________________________
Cell Phone Number
ENROLLMENT FORM
CHILD AND ADULT CARE FOOD PROGRAM

FAMILY INFORMATION:
Parent Name: ____________________________ Telephone____________________
Address: ________________________________________________
City, State, Zip: ____________________________________________

CHILD ENROLLMENT INFORMATION:
Name (Last, First, MI): _________________________________________
Birthdate: ___________ Enrollment date: ___________ Withdrawal: ___________
Hours and days child will be in care: ________________________________
Child will be in care during: _____ Breakfast _____ Lunch _____ Afternoon Snack
_____ I have received information on the WIC Program and have been given a copy of the “Building for the
Future Brochure.”
Parent Signature: ____________________________ Date ______________________

CHILD ENROLLMENT INFORMATION:
Name (Last, First, MI): _________________________________________
Birthdate: ___________ Enrollment date: ___________ Withdrawal: ___________
Hours and days child will be in care: ________________________________
Child will be in care during: _____ Breakfast _____ Lunch _____ Afternoon Snack
_____ I have received information on the WIC Program and have been given a copy of the “Building for the
Future Brochure.”
Parent Signature: ____________________________ Date ______________________

The YWCA does not discriminate against any applicant or participant because of age,
color, disability, national origin, political beliefs, religion or sex.
United Way Agency   EOE

R: 9/2014
CHILD ENROLLMENT INFORMATION:

Name (Last, First, MI): ________________________________

Birthdate: ____________________ Enrollment date: _______________ Withdrawal: _______________

Hours and days child will be in care: ________________________________

Child will be in care during: _____ Breakfast _____ Lunch _____ Afternoon Snack

_____ I have received information on the WIC Program and have been given a copy of the “Building for the Future Brochure.”

Parent Signature: ___________________________________________ Date ____________________

CHILD ENROLLMENT INFORMATION:

Name (Last, First, MI): ________________________________

Birthdate: ____________________ Enrollment date: _______________ Withdrawal: _______________

Hours and days child will be in care: ________________________________

Child will be in care during: _____ Breakfast _____ Lunch _____ Afternoon Snack

_____ I have received information on the WIC Program and have been given a copy of the “Building for the Future Brochure.”

Parent Signature: ___________________________________________ Date ____________________
## CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

**Part 1. All Household Members**

<table>
<thead>
<tr>
<th>Name of Enrolled Child(ren):</th>
<th>CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>* IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.</td>
</tr>
<tr>
<td></td>
<td>CHECK IF NO INCOME</td>
</tr>
</tbody>
</table>

- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]

**Part 2. Benefits:** If any member of your household receives SNAP, TANF, or FDPIR, provide the name and eligibility number for the person who receives benefits. If no one receives these benefits, skip to part 3.

NAME: ___________________________ ELIGIBILITY NUMBER: ___________________________

**Part 3. (Applies only to parents/guardians with children enrolled in a day care home)** If any member of your household receives benefits listed on the enclosed List of Eligible Federal/State Funded Programs (H1660), provide the name of the program and eligibility number:

NAME: ___________________________ ELIGIBILITY NUMBER: ___________________________

Check here if no eligibility number [ ]

**Part 4. Total Household Gross Income—You must tell us how much and how often**

<table>
<thead>
<tr>
<th>A. Name</th>
<th>B. Gross income and how often it was received</th>
</tr>
</thead>
<tbody>
<tr>
<td>(List only) household members with income</td>
<td>Note: Self-employed report income after expenses in box 1</td>
</tr>
<tr>
<td>$200/weekly</td>
<td>$150/twice a month</td>
</tr>
<tr>
<td>$/week</td>
<td>$/month</td>
</tr>
</tbody>
</table>

**Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)**

An adult household member must sign this form. If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the “I do not have a Social Security Number” box. (See Privacy Act Statement on the next page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: ___________________________ Print name: ___________________________

Date: ___________________________

Address: ___________________________ Phone Number: ___________________________

City: ___________________________ State: __________________ Zip Code: __________________

Last four digits of Social Security Number: ___________________________ [ ] I do not have a Social Security Number
### Part 6. Participant’s ethnic and racial identities (optional)

<table>
<thead>
<tr>
<th>Mark one ethnic identity:</th>
<th>Mark one or more racial identities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Hispanic or Latino</td>
<td>☐ Asian</td>
</tr>
<tr>
<td>☐ Not Hispanic or Latino</td>
<td>☐ American Indian or Alaska Native</td>
</tr>
<tr>
<td></td>
<td>☐ White</td>
</tr>
<tr>
<td></td>
<td>☐ Native Hawaiian or Other Pacific Islander</td>
</tr>
</tbody>
</table>

### Part 7. Sharing Information With Other Programs: OPTIONAL

The above information may be disclosed for the purpose of enrolling children in the Children’s Health Insurance Program (CHIP). Parents/guardians are not required to consent to such disclosure and electing not to allow disclosure will not adversely affect a child’s eligibility.

- ☐ I do elect to allow my household information to be disclosed.
- ☐ I do not elect to allow my household information to be disclosed.

---

### Don’t fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: __________________ Per: ☐ Week, ☐ Every 2 Weeks, ☐ Twice A Month, ☐ Month, ☐ Year

Household size: ______________

Categorical Eligibility: ___ Date Withdrawn: __________ Eligibility: Free___ Reduced___ Denied___ Tier I___ Tier II___

Reason: __________________________________________________________

Determining Official’s Signature: _____________________________________ Date: __________

Confirming Official’s Signature: ______________________________________ Date: __________

Follow-up Official’s Signature: ______________________________________ Date: __________

---

### Privacy Act Statement:

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) eligibility number for the participant 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 the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

---

### Non-discrimination Statement:

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA’s TARGET Center at (800) 275-9422 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: [https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf](https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf), from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant’s name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. mail: U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410;
2. fax: (833) 256-1665 or (202) 690-7442; or
3. email: program.intake@usda.gov

This institution is an equal opportunity provider.
FORMULARIO DE CALIFICACIÓN POR INGRESOS PARA
EL BENEFICIO DE COMIDAS DE CACFP (Cuidado para niños)

Parte 1. Todos los miembros del hogar

<table>
<thead>
<tr>
<th>Nombre del niño(s) inscrito(s):</th>
<th>MARQUE SI ES UN HIJO DE CRIANZA (RESPONSABILIDAD LEGAL DE UNA AGENCIA DE ASISTENCIA SOCIAL O TRIBUNAL)</th>
<th>MARQUE SI NO HAY INGRESOS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SI TODOS LOS NIÑOS QUE APARECEN ABAJO SON HIJOS DE CRIANZA, SÁLTESE A LA PARTE 5 Y FIRME ESTE FORMULARIO.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nombre de todos los miembros del hogar</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(Nombre, inicial de segundo nombre, apellido)</td>
<td></td>
</tr>
</tbody>
</table>

Parte 2. Beneficios: Si algún miembro de su hogar recibe SNAP, TANF, o FDPIR, proporcione el nombre y el número de elegibilidad de la persona que recibe los beneficios. Si nadie recibe estos beneficios, vaya a la parte 3.

<table>
<thead>
<tr>
<th>NOMBRE:</th>
<th>NÚMERO DE ELEGIBILIDAD:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Parte 3. (Aplica solamente para padres/guardianes de niños inscritos en guarderías en hogar) Si algún miembro de su hogar recibe beneficios que se encuentren en la Lista de Programas de asistencia Federales/Estatales (H1660), proporcione el nombre del programa y el número de elegibilidad:

<table>
<thead>
<tr>
<th>NOMBRE:</th>
<th>NÚMERO DE ELEGIBILIDAD:</th>
</tr>
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<tbody>
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</tr>
</tbody>
</table>

Marque aquí si no hay ningún número de elegibilidad

Parte 4. Ingreso bruto total de su hogar – Usted debe decirnos cuánto es y la frecuencia en que lo recibe

<table>
<thead>
<tr>
<th>A. Nombre</th>
<th>B. Ingreso bruto y frecuencia en que lo recibe</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Ejemplo)</td>
<td>SOLAMENTE para los que trabajan por cuenta propia, indique ingresos después de gastos en la Casilla 1</td>
</tr>
<tr>
<td>$200/semanales</td>
<td>$150/dos veces por mes</td>
</tr>
</tbody>
</table>

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</table>

Julio 2022
Parte 5. Firma y los cuatro últimos dígitos del número de Seguro Social (Un adulto debe firmar)
Una persona adulta de este hogar debe firmar esta forma. Si se llena la Parte 4, el adulto que firma la forma debe además anotar los cuatro últimos dígitos de su número de Seguro Social o marcar la cajilla que dice: “Yo no tengo número de Seguro Social”. (Vea la Declaración del Acta de Privacidad en la próxima página.)

Yo certifico que toda la información en esta forma es verdadera y se ha reportado todos los ingresos. Yo entiendo que el centro o casa de guardería recibirá fondos Federales a base de la información que yo presento. Yo entiendo que los funcionarios de CACFP puedan verificar la información. Yo entiendo que si doy información que sé que es falsa, las personas que reciben las comidas pueden perder esos beneficios, y yo podría ser procesado legalmente.

Firma aquí: ___________________________ Nombre con letra de molde: ___________________________
Fecha: ___________________________
Dirección: ___________________________ Número de teléfono: ___________________________
Ciudad: ___________________________ Estado: ___________________________ Código Postal: ___________________________
Cuatro últimos dígitos del Número de Seguro Social: * * * * ___________ □ Yo no tengo Número de Seguro Social

Parte 6. Identidad étnica o racial del participante (opcional)
Anoté una identidad étnica: Anote una o más identidades raciales:
□ hispano o latino □ Asiático □ Indígena Norteamericano o Nativo de Alaska
□ No hispano ni latino □ Blanco □ Hawaiano o de otra isla del Pacifico
□ Negro o Africano-Amerciano

Parte 7. Compartir información con otros programas: OPTATIVO
La información de arriba sobre ingresos del hogar puede divulgarse con el fin de inscribir a los niños en el Programa de Seguro de Salud para Niños (CHIP). Los padres/tutores no están obligados a dar consentimiento respecto a dicha divulgación y el optar por no divulgar no afectará adversamente a los beneficios del niño.

□ Sí acepto que la información de mi familia sea divulgada.
□ No acepto que la información de mi familia sea divulgada.

No rellene esta parte. Esto es para uso oficial solamente.
Conversión de Ingresos Anuales: Semanal x 52, Cada 2 semanas x 26, Dos veces por Mes x 24, Mensual x 12
Ingresos totales: ___________ Por: □ Semana, □ Cada 2 semanas, □ Dos veces por mes, □ Mes, □ Año Tamaño de la familia: ___________
Calificación categórica: _______ Fecha retirado: _______ Calificación: Gratuita___ Reducida___ Negada____ Nivel I____ Nivel II____
Motivo: ___________________________
Firma del Funcionario que Decide: ___________________________ Fecha: ___________________________
Firma del Funcionario que Confirma: ___________________________ Fecha: ___________________________
Firma del Funcionario que hace el seguimiento: ___________________________ Fecha: ___________________________

Julio 2022
Calificación por Ingresos para el Beneficio de Comidas del CACFP
Formulario de Cuidado de Niños
Página 2
Declaración del Acta de Privacidad
La Ley Nacional de Almuerzo Escolar Richard B. Russell exige la información que se pide en esta solicitud. Usted no está obligado a dar la información, pero si se niega a hacerlo, no podemos aprobar que el participante reciba comidas gratuitas o a un precio reducido. Usted debe incluir los cuatro últimos dígitos del número de Seguro Social de la persona adulta de su hogar quien firma la solicitud. El número del Seguro Social no es necesario cuando aplica como representante de un niño adoptivo o indica un número de elegibilidad de los siguientes programas: Programa de Asistencia de Nutrición Suplementaria (SNAP), Asistencia Temporal para Familias Necesitadas (TANF) o el programa de distribución de alimentos en reservaciones indígenas (FDPIR). El número de elegibilidad puede ser del participante u otro identificador (FDPIR) o cuando se indica que algún miembro adulto de la familia firme y no tenga un número del Seguro Social. Nosotros utilizaremos la información para determinar si el participante califica para recibir comidas gratuitas o de precio reducido, así como para la administración y el cumplimiento legal del programa.

Declaración de No Discriminación:
De acuerdo con la ley federal de derechos civiles y las normas y políticas de derechos civiles del Departamento de Agricultura de los Estados Unidos (USDA), esta entidad está prohibida de discriminar por motivos de raza, color, origen nacional, sexo (incluyendo identidad de género y orientación sexual), discapacidad, edad, o represalia o retorsión por actividades previas de derechos civiles.

La información sobre el programa puede estar disponible en otros idiomas que no sean el inglés. Las personas con discapacidades que requieren medios alternos de comunicación para obtener la información del programa (por ejemplo, Braille, letra grande, cinta de audio, lenguaje de señas americano (ASL), etc.) deben comunicarse con la agencia local o estatal responsable de administrar el programa o con el Centro ARGÉT del USDA al (202) 720-2600 (voz y TTY) o comuníquese con el USDA a través del Servicio Federal de Retransmisión al (800) 877-8339.

Para presentar una queja por discriminación en el programa, el reclamante debe llenar un formulario AD-3027, presentarlo a la oficina de USDA, llamando al (866) 632-9992, o escribiendo una carta dirigida a USDA. La carta debe contener el nombre del demandante, la dirección, el número de teléfono y una descripción escrita de la acción discriminatoria alegada con suficiente detalle para informar al Subsecretario de Derechos Civiles (ASCR) sobre la naturaleza y fecha de una presunta violación de derechos civiles. El formulario AD-3027 completado o la carta debe presentarse a USDA por:

(1) correo: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (833)256-1665 o (202) 690-7442; o

(3) correo electrónico: program.intake@usda.gov.

Esta entidad es un proveedor que brinda igualdad de oportunidades.
Dear Parents/Guardians,

If your child will need any non-prescription lotions, ointments and/or insect repellent applied while attending care, please check all that apply and sign for permission to apply any of the following items.

I __________________________ authorize ____________ to apply the following checked items on my child,________________________.

- [ ] Sun Screen
- [ ] Lotion
- [ ] Lip Protectant
- [ ] Insect Repellent
- [ ] Diaper Rash Ointment

Signature (parent/guardian) ____________________________ Date ____________

*Any of the requested items will be provided by a parent or guardian.
CHILD’S MEDICAL EXAM

I have examined ______________________ and found him/her to be

(Child’s name)

free of communicable disease and able to participate in the child care program.

Special medicine/medical consideration: ______________________________________

___________________________________________________________________________

Special dietary needs: _______________________________________________________

___________________________________________________________________________

_________________________________________

Signature M.D.
(U.S. Physician required by YWCA Policy)

_________________________________________

Address
**TB Questionnaire**

Name of Child ___________________________ Date of Birth ____________

Organization administering questionnaire ___________________________ Date ____________

Tuberculosis (TB) is a disease caused by TB germs and is usually transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child.

Adults who have active TB disease usually have many of the following symptoms: cough for more than two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills and night sweats.

A person can have TB germs in his or her body but not have active TB disease (this is called Latent TB infection or LTBI).

Tuberculosis is preventable and treatable. TB skin testing (often called the PPD or Mantoux test) is used to see if your child has been infected with TB germs. No vaccine is recommended for use in the United States to prevent tuberculosis. The skin test is not a vaccination against TB.

We need your help to find out if your child has been exposed to tuberculosis.

<table>
<thead>
<tr>
<th>Place a mark in the appropriate box:</th>
<th>Yes</th>
<th>No</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB can cause fever of long duration, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood. As far as you know: has your child been around anyone with any of these symptoms or problems? or has your child had any of these symptoms or problems? or has your child been around anyone sick with TB?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your child traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If so, specify which country/countries?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To your knowledge, has your child spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from another country?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your child been tested for TB?</td>
<td>Yes (if yes, specify date __/____)</td>
<td>No__</td>
<td></td>
</tr>
<tr>
<td>Has your child ever had a positive TB skin test?</td>
<td>Yes (if yes, specify date __/____)</td>
<td>No__</td>
<td></td>
</tr>
</tbody>
</table>

**For school/healthcare provider use only**

PPD administered Yes__ No__
If yes,
Date administered ____ / ____ / ____ Date read ____ / ____ / ____ Result of PPD test ______ mm response

Type of service provider (i.e. school, Health Steps, other clinics) __________________________________________________________

PPD provider ___________________________ signature ___________________________ printed name ___________________________

Provider phone number ___________________________

City ___________________________ County ___________________________

If positive, referral to healthcare provider Yes__ No__
If yes, name of provider ____________________________________________

**Texas Department of State Health Service**

**Cuestionario de Tuberculosis**

EF12-11494 TB Questionnaire for Children (Rev. 08/04)
Nombre del niño o niña

Organización YWCA Mabee Early Learning Center

La Tuberculosis (TB) es una enfermedad causada por gérmenes de TB y en la mayoría de los casos es transmitida por una persona adulta con tuberculosis pulmonar activa. Se transmite a otra persona por la tos y por el estornudo al expeler gérmenes de TB al aire que pueden ser respirados por los niños.

Los adultos que tienen la enfermedad activa casi siempre tienen varios de los siguientes síntomas: tos con duración de más de dos semanas, pérdida de apetito, pérdida de peso de diez libras o más en un período corto de tiempo, fiebre, escalofríos y sudores nocturnos.

Una persona puede tener gérmenes de TB en su cuerpo pero no tener la enfermedad activa. Esto se llama infección latente de TB (o LTBI por su sigla en inglés)

La TB es prevenible y curable. La prueba tuberculina, también llamada PPD o prueba de Mantoux, se utiliza para saber si su niño o niña ha sido infectado/a con el germen de TB. No se recomienda ninguna vacuna para prevenir la tuberculosis. La prueba tuberculina no es una vacuna contra la tuberculosis.

Necesitamos de su ayuda para saber si su niño/niña ha sido expuesto/a a la tuberculosis.

<table>
<thead>
<tr>
<th></th>
<th>Sí</th>
<th>No</th>
<th>No se sabe</th>
</tr>
</thead>
<tbody>
<tr>
<td>La tuberculosis puede causar fiebre de larga duración, pérdida de peso inexplicable, tos severa (con más de dos semanas de duración), o tos con sangre. ¿Es de su conocimiento si: su niño o niña ha estado cerca de algún adulto con esos síntomas o problemas? su niño o niña ha tenido algunos de estos síntomas o problemas? su niño o niña ha estado cerca de alguna persona enferma de tuberculosis?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Su niño o niña nació en México en o cualquier otro país de América Latina, el Caribe, África, Europa Oriental o Asia?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Su niño o niña viajó a México o a cualquier otro país de América Latina, el Caribe, África, Europa Oriental o Asia durante el último año por más de 3 semanas?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Si su respuesta es positiva, favor de especificar a qué país o países.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Es de su conocimiento, si su niño o niña pasó un tiempo (más de 3 semanas) con alguna persona que es o ha sido usuario de droga intravenosa (IV), infectado por VIH, en la prisión, o haya llegado recientemente a los Estados Unidos?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¿A su niño o niña se le ha realizado la prueba tuberculinita recientemente? Sí (si sí, especifique la fecha ___/___) No

¿Su niño o niña alguna vez tuvo reacción positiva a la tuberculina? Sí (si sí, especifique la fecha ___/___) No

Solamente para uso de la escuela o del proveedor de servicios médicos

*************************************************************************************

¿Se administró PPD? Sí No

Si sí,
Fecha en que fue administrada ___/___/____ Fecha de lectura ___/___/____ Resultado de la prueba ____ mm

Tipo de proveedor de servicio (ej.: escuela, Health Steps, otras clínicas)

Administrator de PPD

Firma

nombre en letra de molde (imprenta)

Número de teléfono del administrador de PPD

Ciudad_________________________ Condado_________________________

Si resultó positivo, ¿se refirió al proveedor de servicios de salud? Sí No

Si sí, nombre del proveedor (médico o clínica, etc.)

EF12-11494A (Rev. 08/04)