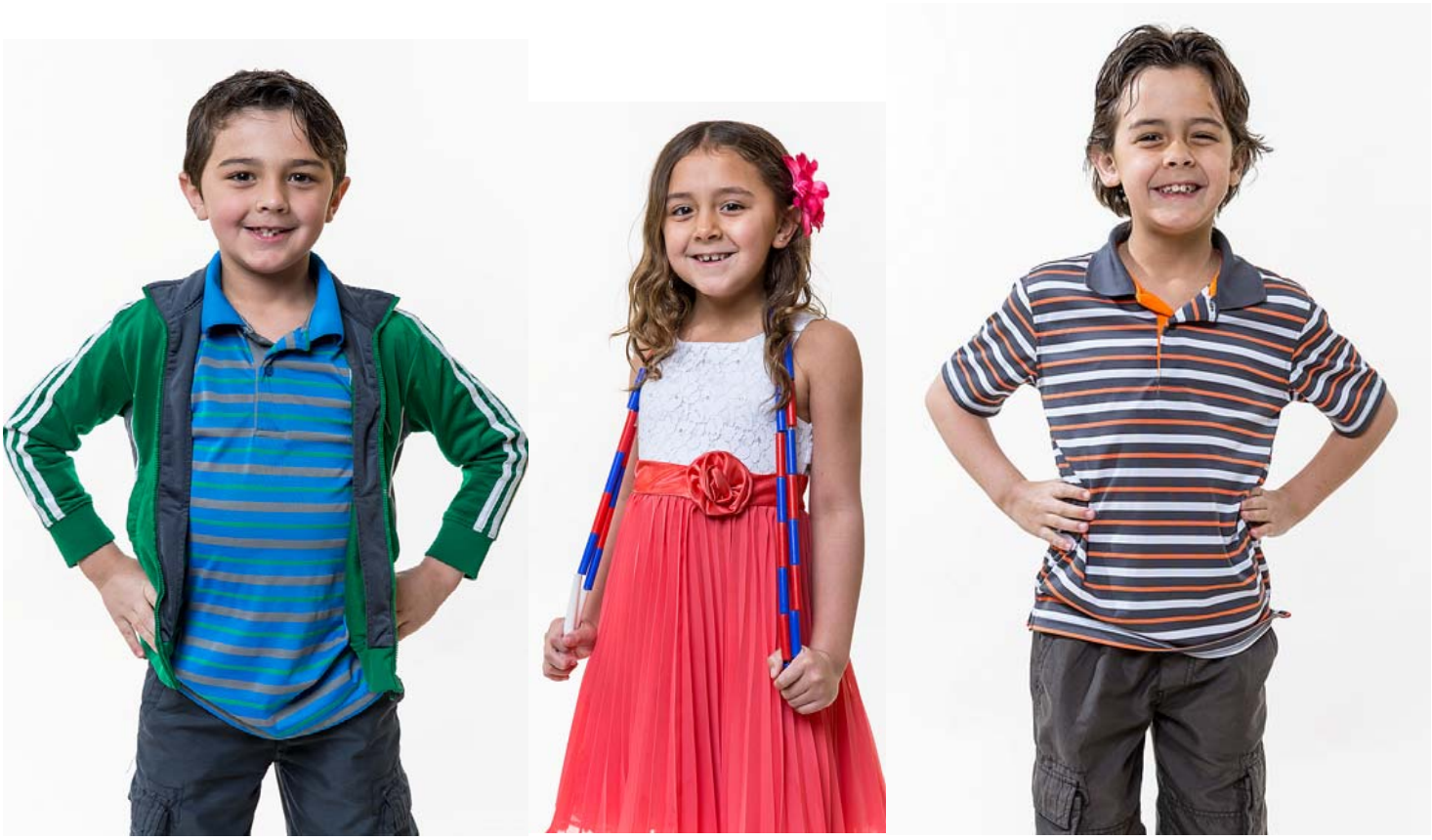
FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY



BUILDING STRONG BRIGHT FUTURES

Healthy Out of School Time
Before & After School Enrichment
YMCA of Marquette County

Information on Ishpeming, Negaunee and KI Sawyer/Gwinn areas provided inside

YMCA of Marquette County 1420 Pine Street, Marquette MI 49855
P 906.227.9622 **F** 906.227.9248 **W** ymcamqt.org

WELCOME

Youth Development is the **social-emotional, cognitive** and **physical** process that all youth uniquely experience from **birth to career**; nourishing their need to be loved, spiritually grounded, educated, competent, and healthy.

Thank you for allowing us to serve your child in our YMCA Before and After School Youth Development program. We look forward to the year ahead and hope the information in this packet will help answer your questions.

If you need further assistance or wish to speak to our on our YMCA staff team members, please refer to the contact information below. As always, we appreciate your feedback and look forward to getting to know you and your family.

-Youth Development Center Staff
YMCA of Marquette County

YMCA YOUTH DEVELOPMENT CONTACT INFORMATION

WEBSITE: ymcamqt.org/participate/youth-development/index.html

YMCA of Marquette County - Birchview Location

Ben Platt
bplatt@ymcamqt.org
906.227.9622

YMCA of Marquette County - Lakeivew Location

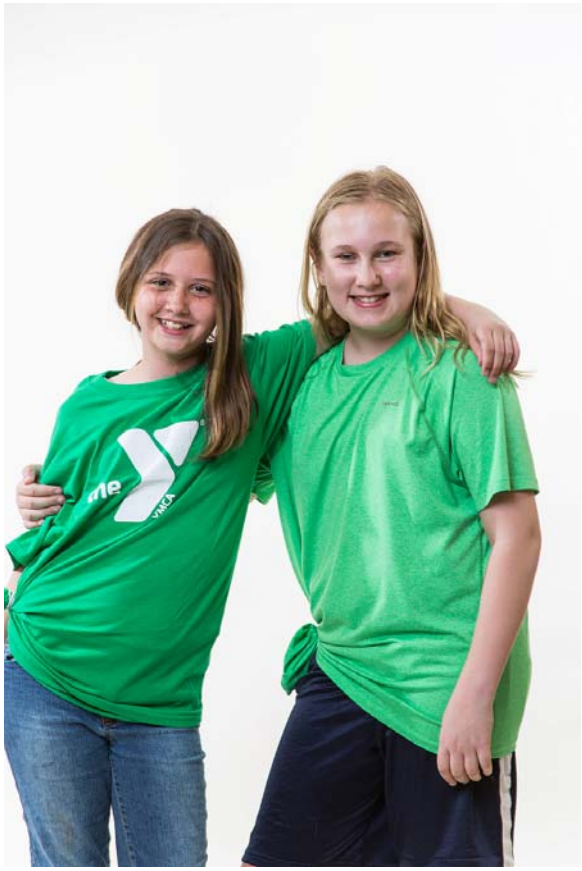
Ben Platt
bplatt@ymcamqt.org
906.227.9622

YMCA of Marquette County - Gilbert Elementary Location

Amber Ostlund
aostlund@ymcamqt.org
06.372.4044

YMCA of Marquette County - KI Sawyer Location

Amber Ostlund
aostlund@ymcamqt.org
Child Development Leader
906.372.4044



ABOUT US

The YMCA Before and After School program follows the Food & Fun After School curriculum. The Food and Fun curriculum is designed to help kids develop healthy habits during out of school time. Eleven teaching units help the program infuse healthy snacks and recipes, physically active games, and creative learning activities into regular program schedules. The Food & Fun curriculum supports the skills and development set forth by the Common Core State Standards, which have been adopted by 45 states to date. Kids enrolled in the YMCA Before and Afterschool Program will receive a healthy afterschool snack, homework help, and fun, active games that encourage kids to live and be healthy!

BIRCHVIEW ELEMENTARY

Monday - Friday

Before - 6:45am - 8:05am
After - 3:25pm - 6:00pm
Grades K - 5

GILBERT ELEMENTARY

Monday - Friday

Before - 7:00am - 8:15am
After - 3:15pm - 6:00pm
Grades K - 5

KI SAWYER

Monday - Friday

Before - 7:00am - 8:30am
After - 3:45pm - 6:00pm
Grades k - 5

LAKEVIEW ELEMENTARY

Monday - Friday

Before - 6:45am - 8:45am
After - 3:45pm - 6:00pm
Grades 1 - 5

HOW TO REGISTER

To enroll a child, parents must complete the registration forms required for state regulations. Parents are required to keep children's records up to date with changes in phone numbers, addresses, employers, etc.

Enrollment inquiries are received year around. Enrollment is on a first come, first serve basis. There are limits on the number of children who can be served. Sometimes a waiting list may be necessary. Parents are required to notify the YMCA of withdrawal so records can be adjusted accordingly. Parents are required to provide a weekly schedule of attendance; this allows the YMCA to properly staff the program.
Schedules are due Friday prior to the start of each week.

PAYMENT INFORMATION

Payment will be taken weekly (Fridays, for the previous week) Payments will be made through automatic withdrawal from your bank account or credit card. If your automatic withdrawal is denied, you will be charged a $25 fee.
Fee: $3 a day or $15 a week

SUSPENSION AND TERMINATION FOR LATE PAYMENT

If the Program Director has not received payment from Parent for billed Fees on or before the next scheduled day of Child's attendance after payment is due ("Overdue Payment"), the YMCA Has the right to refuse to admit Child to the program until parent makes such Overdue Payment in full.

DHS SUBSIDY

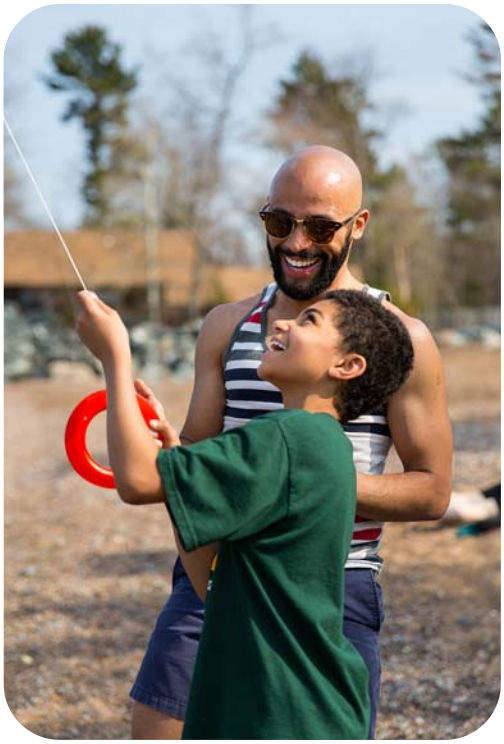
The YMCA Before and Afterschool Program is a state licensed program, which means DHS subsidy is available if you quality. To find out if you qualify, please call DHS, 228.0747.
We will not offer a program on snow days or scheduled days off (The YMCA holds a days off program at it's Marquette location)

DRAFT DATES

Draft #1: September 18th for week #1 (Sept. 8th-11th)
Draft #2: September25th for week #2 (Sept. 14th-18th)
Draft #3: October 3rd for week #3 (Sept. 21st-25th)
Draft #4: October 9th for week #4 (Sept. 28th-Oct. 2nd)
Draft #5: October 16th for week #5 (Oct. 5th-9th)
Draft #6: October 23rd for week #6 (Oct. 12th-16th)
Draft #7: October 30th for week #7 (Oct. 19th-23rd)
Draft #8: November 6th for week #8 (Oct. 26th-30th)
Draft #9: November 13th for week #9 (Nov 2nd-6th)
Draft #10: November 20th for week #10 (Nov 9th-13th)
Draft# 11: November 27th for week #11 (Nov 16th-20th)
Draft #12: December 4th for week #12 (Nov.23rd-27th)
Draft #13: December11th for week #13 (Nov 30th-Dec4th)
Draft #14: December 18th for week #14 (Dec 7th-11th)
Draft #15: December 25th for week #15 (Dec14th-18th)
Draft #16: January 1st for week #16 (Dec 21st-22nd)
Draft #17: January 15th for week #17 (Jan 4th-8th)
Draft #18: January 22nd for week #18 (Jan 11th-15th)
Draft #19: January 29th for week #19 (Jan 18th-22nd)
Draft # 20: February 5th for week #20 (Jan 25th-29th)
Draft #21: February 12th for week #21 (Feb 1st-5th)
Draft #22: February 19th for week #22 (Feb 8th-12th)
Draft #23: February 26th for week #23 (Feb15th-19th)
Draft #24: March 4th for week #24 (Feb 22nd-26th)
Draft #25: March 11th for week #25 (Feb 29th-March 4th)
Draft #26: March 18th for week #26 (March 7th-11th)
Draft #27: March 25th for week #27 (March 14th-18th)
Draft #28: April 1st for week #28 (March 21st-24th)
Draft #29: April 15th for week #29 (April 4th-8th)
Draft #30: April 22nd for week #30 (April 11th-15th)
Draft #31: April 29th for week #31 (April 18th-22nd)
Draft #32: May 6th for week #32 (April 25th-29th)
Draft #33: May 13th for week #33 (May 2nd-6th)
Draft #34: May 20th for week #34 (May 9th-13th)
Draft #35: May 27th for week #35 (May 16th-20th)
Draft #36: June 3rd for week #36 (May 23rd-26th)
Draft #37: June 10th for week #37 (May 31st-June3rd)
Draft #38: June17th for week #38 (June 6th and 7th)

Please fill out the parent registration packet in full and return to the YMCA in order to reserve your child's spot. Incomplete packets will NOT be accepted.

Parent registration packet, pages 5-18



HEALHTY MEALS & HEALTHY SNACKS FOR EVERYONE

The YMCA Before and After School Program (BAS) offers healthy meals/snacks to all enrolled children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached Household Income Eligibility Statement (IES). In addition, by filling out this form, we will be able to determine if your child(ren) qualifies for free or reduced price meals.

1. Do I need to fill out an IES for each of my children in day care? You may complete and submit one CACFP Household Income Eligibility Statement for all children enrolled in child care in your household **only** if the children in child care are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. **Return the completed form to: The YMCA Before and After School Program**

2. Which child care institutions can receive free meal reimbursement without providing household income information? Children in households receiving Food Assistance Program (FAP), Family Independence Program (FIP), or Food Distribution Program on Indian Reservations (FDPIR) can get free meals. Foster children and children enrolled in Head Start and Even Start are also eligible for free meals.

3. Who can get reduced price meals? Your children can get low cost meals if your household income is within the reduced price limits on the federal income eligibility guidelines, effective July 1, 2011, until June 30, 2012, shown below:

Family Size	Yearly Income	Monthly Income
1	$20,147	$1,679
2	$27,214	$2,268
3	$34,281	$2,857
4	$41,348	$3,446
For each additional family member add:	$7,067	$589

Refer to the Instructions for Parents/Guardians Household Income Eligibility Statement on how to complete the IES. Find the category that most closely defines your household and follow the directions for completing each part of the IES. If your household income is greater than the levels shown on the above CACFP income guidelines, it is not necessary for you to complete the IES.

Your family may be eligible to receive health insurance, called MIChild, through the State of Michigan. MIChild is a health insurance program for uninsured children of Michigan's working families. To determine if your family is eligible, call 1-888-988-6300 for an application or access an online application at www.michigan.gov/michild. At the web address, you can also access the MIChild brochure that briefly explains the insurance program.

4. May I fill out a form if someone in my household is not a U.S. citizen? Yes. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center.

5. Who should I include as members of my household? You must include all people in your household (such as grandparents, other relatives, or friends who live with you). You must include yourself and all children who live with you. You also may include foster children who live with you.

HEALTHY MEALS & HEALTHY SNACKS FOR EVERYONE

6. How do I report income information and changes in employment status? The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household size according to the federal income eligibility guidelines listed above, the center will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or by providing a current FAP, FIP, or FDPIR case number, you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the eligibility standards.

7. What if my income is not always the same? List the amount that you normally receive. For example, if you normally receive $1,000 each month, but you missed some work last month and only received $900, put down that you receive $1,000 per month. If you normally get overtime, include it, but not if you only get it sometimes.

8. What if I have foster children? Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the IES, but are not required to include payments received for the foster child as income.

9. We are in the military. Do we include our housing and supplemental allowances as income? If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex, age or disability.

IF you have any questions please don't hesitate to ask
Sincerely,

Ben Platt
School Age Program Director

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 toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

Participant's Name_____

Address_____

City_____ State _____ Zip Code _____

Telephone Number _____ Date of Birth ____/____/____

Age_____ Sex **M** **F**

☐ **Birchview** Day Rate $3 Full Week $15

☐ **Gilbert** Day Rate $3 Full Week $15

KI Sawyer Day Rate $3 Full Week $15

☐ **Lakeview** Day Rate $3 Full Week $15

MONTH _____

Schedules must be provided Friday, for the week in advance
Schedules can be emailed to Ben at bplatt@ymcamqt.org

Circle when in attendance	Monday	Tuesday	Wednesday	Thursday	Friday
1st week _____-_____	AM PM Both	AM PM Both	AM PM Both	AM PM Both	AM PM Both
2nd week _____-_____	AM PM Both	AM PM Both	AM PM Both	AM PM Both	AM PM Both
3rd week _____-_____	AM PM Both	AM PM Both	AM PM Both	AM PM Both	AM PM Both
4th week _____-_____	AM PM Both	AM PM Both	AM PM Both	AM PM Both	AM PM Both

Fee's will be drafted weekly on Fridays for the week prior. We require either Credit/Debit information or Bank information (Checking or savings) Please see draft schedule on page 3.

CREDIT/DEBIT CARD FORM

Please complete all fields legibly!

Name: _____
(as it appears on card)

Billing Address: _____

City, State, Zip: _____

Credit Card Number: _____

Expiration Date: _____ ☐ VISA ☐ MasterCard ☐ American Express ☐ Discover

CID#: _____ Signature: _____

Today's Date: _____Staff initials: _____

BANK INFORMATION

Name on Account:_____

Routing Number: _____

Account Number:_____

Account type: _____Checking _____Savings

RELEASE FROM LIABILITY AND PHOTO RELEASE

Please read this carefully. When you sign this form you will be giving up important legal rights. Program fees are non-refundable. **Release from liability:** In consideration of the acceptance of my program application, I intend to be legally bound, for not only myself but also for my heirs, my executors, and my administrators. In signing this release from liability I waive and release everyone connected with the YMCA (staff & volunteers) from any and all liability which may arise from my or my child's participation in YMCA sponsored activities. In addition, I hereby grant my full and irrevocable consent to release any photographs/images to the YMCA of Marquette County for commercial and art purposed in any medium of advertising or communication.

Parent's Signature: _____ Date: _____

SUNSCREEN RELEASE

Sunscreen SPF 30 is provided by the YMCA for a fee. **We will be charging a one-time fee of $15.00 for the school year if you opt to use the YMCA-provided sunscreen.** This will be charged upon enrollment. This charge will help to defray the cost of the sunscreen. We use a Coppertone Sport Spray.

☐ I give permission for staff to apply Coppertone Sport Spray to my child when he or she will be playing outside.

☐ I give staff permission to apply the sunscreen that I have provided to my child when he or she will be playing outside. Sunscreen must be labeled with your child's full name. Brand: _____

☐ **NO.** Do not apply sunscreen to my child under any circumstances. I understand the dangers and risks associated with the harmful effects of UV Rays and choose not to have my child protected with sunscreen. I understand that my child may not be allowed to play outside without sunscreen if the UV rating is above 5.

Parent's Signature: _____ Date: _____

LICENSING NOTEBOOK NOTIFICATION

All child care centers must maintain a licensing notebook which includes all licensing inspection reports, special investigation reports, and all related corrective action plans (CAP). The notebook must also include a summary sheet outlining all the reports and CAPs contained in the notebook. We are required by law to notify parents of the notebook and that it is available for review during regular business hours.

Please read and initial each statement:

_____ I am aware that the YMCA of Marquette County maintains licensing notebook of all licensing inspection reports, special investigation reports and all related corrective action plans at the center indicated on the reverse side.

_____ I am aware that the YMCA of Marquette County licensing notebook is available for parents to review at the center indicated on the reverse side during regular business hours.

_____ I am aware that licensing inspection reports from the past two years are available on the Bureau of Children and Adult Licensing website at: **www.michigan.gov/michildcare**

Parent's Signature: _____ Date: _____

WE ARE NOT RESPONSIBLE FOR LOST, STOLEN, OR BROKEN ITEMS.

HEALTH & IMMUNIZATION STATEMENT

Childs Name_____

☐ I certify that my child is in good health with any activity restrictions noted below.

☐ I certify that my child's immunizations are up-to-date.

☐ I certify that my child's immunization record (or appropriate waiver) is on file with my child's school.

Activity Restrictions:

_____

_____

_____

_____

Parent's Signature: _____ Date: _____

PARTICIPATION AGREEMENT

In signing this agreement, I specifically assume all risks of injury arising out of my (my child's) presence on the premises of the YMCA of Marquette County, the use of it's equipment or facility, and my (my child's) participation in its activities, whether on its premises or at another location, and form myself and my heirs and assigns to hereby waive, release and agree to hold from all claims for damages the YMCA and its officers, directors, members, volunteers, employees or agents.

I have read and agree to follow the rules outlines in the YMCA Before and Afterschool Program handbook.

I have read this agreement and I fully understand its term, understand that I have given up substantial rights by signing it, and have signed it freely and voluntarily without inducement, assurance or guarantee being made to me and intend my signature to be a complete and conditional release of all liability to the greatest extend allowed by law.

Parent's Signature: _____ Date: _____

PLAYGROUND EXEMPTION

☐ I understand that the Before and After School Program will be using the Birchview and Lakeview Elementary School Playground.

☐ I understand that the Birchview and Lakeview Elementary School Playground has not been inspected by a Certified Playground Inspector and the equipment may not be CPSC approved.

☐ I understand that the Before and After School Programs are exempt from Rule 170 (R 400.8170 Out door Play Area), Sub rule 11.

Parent's Signature: _____ Date: _____

CHILD PICK– UP AUTHORIZATION FORM

Child's Name _____

Effective Dates (Start)_____ (End) _____

Parent/ Guardian allowed to pick up:

Name _____

Relationship _____

Address _____

Work Number_____ Cell Number _____

Home Phone _____

Name _____

Relationship _____

Address _____

Work Number_____ Cell Number _____

Home Phone _____

I, _____ Authorize the following people to pick up my child and be contacted in the event of an emergency from the YMCA of Marquette County BAS program. In doing so, I relieve the YMCA of Marquette County of All responsibility for my child after he/she has been released from the program. Attempts will always be made to reach the parents/ guardians first.
The adults listed below are authorized to pick up my child when I am not available.
(Identification will be required).

Name_____

Address _____

Work Number_____ Cell Number _____

Name_____

Address _____

Work Number_____ Cell Number _____

Return this completed form to: *YMCA Early Childhood Development Center*

Household Income Eligibility Statement

Part 1 – Households Receiving Food Assistance Program (FAP), Family Independence Program (FIP), or Food Distribution Program on Indian Reservations (FDPIR)

If any member of your household receives FAP, FIP, or FDPIR, provide the name and case number for the person who receives the benefits.

Name:_____ Case Number:_____

Part 2 – Household Information

First and Last Names of All Household Members, Related and Unrelated	Enrolled for Child Care (✓)	Age	Birth Date	Foster Child (✓)	Monthly Earnings from Work (before deductions)	Monthly Welfare, Child Support, or Alimony	All Other Income (Indicate source and amount)	Check if No Income (✓)

Part 3 – All Households - Signature and Last Four (4) Digits of Adult Social Security Number (Adult household member MUST sign and date)

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 receive 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.

Signature: _____ Print Name:_____ Date: _____

Last four digits of Social Security number: XXX-XX- ☐☐☐☐ ☐ I do not have a Social Security number

For Institution Use Only		
Total Household Members:	Total Monthly Income: $	APPROVED CATEGORY Categorical Eligibility (A/Free): Foster FIP FAP FDPIR
Institution Official Signature:	Approval Date:	Other Household Children: A (Free) B (Reduced) C (Paid)

This form is valid for 12 months from the date of institution signature. Approval date and institution signature are required.

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 Food Assistance Program (FAP), Family Independence Program (FIP), or Food Distribution Program on Indian Reservations (FDPIR) case 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

This explains what to do if you believe you have been treated unfairly. "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 toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

MICHIGAN Department of Education

Revised 7/12

CHILD INFORMATION RECORD

State of Michigan Department of Human Services - Bureau of Children and Adult Licensing

Instructions: Unless otherwise indicated, all requested information must be provided. If the information is not known or does not apply, "unknown" or "none" is the required response. A blank field, a line through a field or "N/A" are not acceptable responses.

For Provider Use Only: Date of Admission	Date of Discharge

Name of Child (Last, First, Middle Initial)				Child's Date of Birth
Address (Number and Street, Building/Apartment Number)		City	State	Zip Code
Father/Legal Guardian's Name	Home Phone ( )	Mother/Legal Guardian's Name		Home Phone ( )
Home Address (if not child's address)	Cell Phone ( )	Home Address (if not child's address)		Cell Phone ( )
City / State	Zip Code	City	State	Zip Code
Email Address (optional)		Email Address (optional)		
Employer Name	Work Phone ( )	Employer Name		Work Phone ( )
Name of Child's Physician or Health Clinic		Physician's or Health Clinic's Phone Number ( )		
Hospital Preferred for Emergency Treatment (optional)				
Allergies, Special Needs and Special Instructions (Attach additional sheets, if necessary.)				

BCAL-3731 (Rev. 7-12) Previous editions 9-09, 3-08, 10-07, & 1-06 may be used until 12/31/13.

See Reverse Side

Emergency Contact & Release of Child: List all individuals,including parents/legal guardians, in order of preference, to be contacted in an emergency. If possible, include at least one person other than the parents/legal guardians to be contacted in an emergency and to whom the child can be released. The second phone number column can be left blank. (If more individuals, attach additional sheets.)

1.	( )	( )
2.	( )	( )
3.	( )	( )

Release of Child Only: List all individuals, other than the parents/legal guardians, to whom the child may be released. (If more individuals, attach additional sheets.)

1.	( )	2.	( )
3.	( )	4.	( )

I give permission to _____ , licensed by the Department of Human Services
(Provider's Name)

to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care.

Signature of Parent or Guardian	Date Signed

Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

AUTHORITY: 1973 PA 116
COMPLETION: Required
PENALTY: Rule Violation Citation.

BCAL-3731 (Rev. 7-12) Previous editions 9-09,3-08, 10-07, & 1-06 may be used until 12/31/13.

MEDICATION PERMISSION AND INSTRUCTIONS
CHILD CARE HOMES AND CENTERS
STATE OF MICHIGAN
Department of Human Services
Bureau of Children and Adult Licensing

If you are giving or applying any medication to a child in care, the following must be completed by the parent for **each** medication. An interruption in medication will require a new permission form.

TO BE COMPLETED BY PARENT

I give my permission for _____ to give or apply the medication
(Caregiver, Facility)

_____ , to my child _____ , as follows:
(Specify, prescribed medication/over the counter product) (Child's Name)

DIRECTIONS:

1. Date to Begin Giving Medication	2. Date to Stop Medication
3. Times Medication is to be Given	4. Amount (dosage) of Medication Each Time Given
5. Storage of Medication	
6. Other Directions, if Any	
Signature of Parent	Date

TO BE COMPLETED BY THE CAREGIVER GIVING THE MEDICATION:

DATE	TIME	AMOUNT GIVEN	CAREGIVER'S NAME	CAREGIVER'S SIGNATURE

It is recommended this form be reviewed with the parent every 3 months if the medication is ongoing.

STOP HERE
Unless you are eligible for DHS.

Please return completed forms to DHS

CHILD DEVELOPMENT AND CARE (CDC) APPLICATION

State of Michigan
Department of Human Services(DHS)

FOR DHS USE ONLY

Case Name		
Case Number	DHS Specialist	
DHS Office		Date

INSTRUCTIONS: • You must live in Michigan. • Your completed and signed application must be received by DHS before eligibility is determined. • Providing your Social Security Number (SSN) is voluntary. If you do provide it, the SSN may be used for establishing identity and for tracking and reporting purposes.

SECTION 1 – APPLICANT INFORMATION

1. Full name of applicant (*First, middle, last*)
2. Former/maiden name
3. Marital status
☐ Never Married ☐ Married ☐ Divorced
☐ Separated ☐ Widowed
4. Authorized representative name (*First, middle, last*)
5. Authorized representative address
6. Will the authorized representative be providing care for any of the children on this application?
☐ No ☐ Yes If yes ▸ Name of child(ren):
7. Check where you live:
☐ House/apartment/mobile home ☐ Homeless ☐ Other
8. Address where you live, or address of facility (number, street, rural route, apartment/lot number)

City | State | ZIP code | County

9. Mailing address (if different from above or PO box)

City | State | ZIP code | County

10. Home phone | 11. Cell phone | 12. Work phone | 13. TTY #

14. Phone number where we can leave a message | Whose is it? (name/relationship) | 15. Email address

16. Ethnicity (optional)
☐ Hispanic/Latino
☐ Non-Hispanic/Latino

17. Race (optional)
☐ American Indian/Alaska Native – Enter tribe name ______________ ☐ Native Hawaiian/Other Pacific Islander
☐ Asian ☐ Black/African American ☐ White

18. I need child care services for (*Check **all** that apply.*)
☐ Work
☐ High School or GED Completion
☐ Approved Education/Training/Employment Preparation
☐ Treatment for Health or Social Condition (explain):
____

19. I need study time for (*Check **all** that apply.*) | Number of weekly hours
☐ High School or GED Completion ______________
☐ Approved Education/Training/ Employment Preparation ______________

SECTION 2 – LIST ALL PERSONS LIVING IN YOUR HOME: (*Attach additional sheet if needed.*)

Name (First, middle, last)	Date of birth	U.S. citizen?	Sex (M/F)	Relationship to you	Social Security Number (*voluntary*)	Does this person attend school?	Receive cash assistance benefits from DHS	Receive SSI benefit?
		☐ No ☐ Yes	☐ M ☐ F	SELF		☐ No ☐ Yes If yes, where and address	☐ No ☐ Yes	☐ No ☐ Yes
		☐ No ☐ Yes	☐ M ☐ F			☐ No ☐ Yes If yes, where and address	☐ No ☐ Yes	☐ No ☐ Yes
		☐ No ☐ Yes	☐ M ☐ F			☐ No ☐ Yes If yes, where and address	☐ No ☐ Yes	☐ No ☐ Yes
		☐ No ☐ Yes	☐ M ☐ F			☐ No ☐ Yes If yes, where and address	☐ No ☐ Yes	☐ No ☐ Yes
		☐ No ☐ Yes	☐ M ☐ F			☐ No ☐ Yes If yes, where and address	☐ No ☐ Yes	☐ No ☐ Yes

CONTINUE ON PAGE 2 ▸

SECTION 3 – LIST CHILDREN IN YOUR HOME WHO NEED CHILD CARE: (*Attach additional sheet if needed.*)

Name of child needing care	Provider Name	Provider ID Number (if known)

SECTION 4 – OTHER INFORMATION: Check all that apply.

☐ I am a foster parent requesting child care **only** for a **foster child(ren)**.

☐ I need child care **only** to participate in a required activity for my **DHS Protective Services** case.

SECTION 5 – INFORMATION ABOUT ALL CHILDREN UNDER AGE 18 WHO LIVE IN YOUR HOME

Complete table below. (*Attach additional sheet if needed.*)

List the full name of all children under the age of 18 who live in your home (*First, middle, last*)	List full name of each child's mother and father. Write "Unknown" if you do not know who the mother or father is. (*First, middle, last*)	Is parent living in the home?	If the child does not live with a parent, who does the child live with and the relationship to the child?	If parent not in the home, ☒ proper box.							Parent's mailing address if different from the applicant.	Does the parent provide child support?
				Married	Divorced	Separated	Prison	Dead	In the military	Absent for other reason		
Child 1	Mother	☐ No ☐ Yes	Name _____ Relationship _____	☐	☐	☐	☐	☐	☐	☐		☐ No ☐ Yes If yes, provide support # if known _____
	Father	☐ No ☐ Yes	Name _____ Relationship _____	☐	☐	☐	☐	☐	☐	☐		☐ No ☐ Yes If yes, provide support # if known _____
Child 2	Mother	☐ No ☐ Yes	Name _____ Relationship _____	☐	☐	☐	☐	☐	☐	☐		☐ No ☐ Yes If yes, provide support # if known _____
	Father	☐ No ☐ Yes	Name _____ Relationship _____	☐	☐	☐	☐	☐	☐	☐		☐ No ☐ Yes If yes, provide support # if known _____
Child 3	Mother	☐ No ☐ Yes	Name _____ Relationship _____	☐	☐	☐	☐	☐	☐	☐		☐ No ☐ Yes If yes, provide support # if known _____
	Father	☐ No ☐ Yes	Name _____ Relationship _____	☐	☐	☐	☐	☐	☐	☐		☐ No ☐ Yes If yes, provide support # if known _____
Child 4	Mother	☐ No ☐ Yes	Name _____ Relationship _____	☐	☐	☐	☐	☐	☐	☐		☐ No ☐ Yes If yes, provide support # if known _____
	Father	☐ No ☐ Yes	Name _____ Relationship _____	☐	☐	☐	☐	☐	☐	☐		☐ No ☐ Yes If yes, provide support # if known _____

CONTINUE ON PAGE 3 ▸

SECTION 6 – SELF-EMPLOYMENT ONLY – List anyone in your home who is self-employed including yourself. Attach current proof. (*Attach additional sheet if needed.*)

Self-employed person	Start date	Business name/address/ phone number	Type of work	Hours of self-employment	Gross monthly income (amount before any expenses)	Date of most recent or last pay check
				Mon _____ Tue _____ Wed _____ Thur _____ Fri _____ Sat _____	$	
Self-employed person	Start date	Business name/address/ phone number	Type of work	Hours of self-employment	Gross monthly income (amount before any expenses)	Date of most recent or last pay check
				Mon _____ Tue _____ Wed _____ Thur _____ Fri _____ Sat _____	$	

SECTION 7 – EMPLOYMENT INCOME – List anyone in your home with any earnings including yourself. Attach current proof. (*Attach additional sheet if needed.*)

Name of working person	Start date	Employer name/address/ phone number	Type of work	Job Title	Work schedule Hours
					Mon _____ Tue _____ Wed _____ Thur _____ Fri _____ Sat _____ Sun _____

If new job, first pay check date	Will employment continue? ☐ Yes ☐ No
Day of week pay is received	Most recent or last pay check date
Average number of hours expected to work _____ per ☐ Week ☐ Pay period	Rate of pay $ _____ ☐ Hourly ☐ Salary ☐ Other _____

How often are checks received?
☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Other _____

Do you receive any of the following?
☐ Bonus ☐ Commission

OR

Do you work Overtime?
☐ Yes ☐ No

▶ If yes, amount $ _____ How often? _____

Do you receive tips not included in your check? ☐ Yes ☐ No

▶ If yes, average tips not included $ _____ Per ☐ Week ☐ Pay period ☐ Other _____

CONTINUE ON PAGE 4 ▶

Name of working person	Start date	Employer name/address/ phone number	Type of work	Job Title	Work schedule Hours Mon Tue Wed Thur Fri Sat Sun

If new job, first pay check date	Will employment continue? ☐ Yes ☐ No
Day of week pay is received	Date of most recent or last pay check date
Average number of hours expected to work _____ per ☐ Week ☐ Pay period	Rate of pay $ _____ ☐ Hourly ☐ Salary ☐ Other _____

How often are checks received?

☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Other _____

Do you receive any of the following?

☐ Bonus ☐ Commission

▸ If yes, amount $ _____

OR

Do you work Overtime?

☐ Yes ☐ No

How often? _____

Do you receive tips not included in your check? ☐ Yes ☐ No

▸ If yes, average tips not included $ _____ Per ☐ Week ☐ Pay period ☐ Other _____

SECTION 8 – UNEARNED INCOME – Attach current proof. (*Attach additional sheet if needed.*)

Does anyone in your household receive, or expect to receive, any other income other than earnings?

☐ No ☐ Yes ▸ Check all boxes that apply and complete the table.

- ☐ Money from friends or relatives, etc.
- ☐ Social Security benefits
- ☐ Unemployment compensation
- ☐ State Disability Assistance (SDA)
- ☐ Pension/retirement benefits
- ☐ Worker's compensation
- ☐ Child support
- ☐ Education grants or loans
- ☐ Gaming distribution (lottery)
- ☐ Income/payments from a tribe (tribal GA, land claims, casino profit sharing, etc.)
- ☐ Housing assistance
- ☐ Disability benefits
- ☐ Crops and farm income
- ☐ Veteran's benefits
- ☐ Military allotments
- ☐ Land contract, mortgage or rental income

  Name of tenant: ▸ _____
- ☐ Other _____

Person(s) receiving/ expecting money	Income source/type listed above	How often received	Amount received	Expected to continue	Date expecting if not yet receiving
			$	☐ No ☐ Yes	
			$	☐ No ☐ Yes	
			$	☐ No ☐ Yes	

SECTION 9 – STATE OF MICHIGAN VOTER REGISTRATION APPLICATION

If you are not already registered to vote at your current address, would you like to register to vote? ☐ Yes ☐ No

NOTE: If you do not check either box, the Department will assume you have decided not to register to vote at this time.

Applying or declining to register to vote will not affect the amount of help that you will be provided by this department. If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration application form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: Secretary of State, PO Box 20126, Lansing, MI 48901-0726.

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SECTION 10 – RIGHTS AND ACKNOWLEDGMENTS:

1. **APPLICATION:** I understand that I have the right to file an application today or at any time, including prior to any interview or appointment, and the application must be approved or denied within 45 days from the day it is received by the DHS.
2. **NON-DISCRIMINATION:** I understand that if I believe I have been discriminated against because of race, sex, religion, age, national origin, color, height, weight, marital status, sexual orientation, gender identity, handicap, or political beliefs, I have the right to file a complaint with the Secretary, Department of Health and Human Services in Washington, D.C.
3. **REPORTING REQUIREMENTS:**
   - I understand that the Department needs to know of any changes in income or circumstances of any person listed on this form.
   - **I will report to the DHS specialist who handles my Child Development and Care (CDC) case, any changes within ten work days of the change.** This includes changes in my employment, school/training, income, child care arrangements (i.e. provider, where care is provided), name, address, phone numbers, household members, marital status, etc., and any other change which may affect my eligibility or the amount of benefits.
   - I understand that if I neglect or refuse to report required changes, or make false or misleading statements, I can be prosecuted for fraud or perjury.

   If you have any doubt about whether you should report a change, call your specialist at the local DHS office.
4. **PROGRAM PENALTIES:** Violation of program rules may result in a disqualification of 6 months, 12 months or a lifetime.
5. **REPAYMENT OF BENEFITS:** I understand that if benefits are overpaid for any reason, the extra benefits received will have to be repaid. If intentional misrepresentation caused the overpayment, the responsible party, including any adult in the program group or the group's authorized representative or provider of goods or services, may be prosecuted for fraud.
6. **HEARINGS:** I understand that if I do **not** agree with any decision made on any matter concerning my case, I have the right to ask for an Administrative Hearing. I understand that I can ask for information about an Administrative Hearing by calling the county DHS office, and that I can request an Administrative Hearing by writing to the local DHS office.
7. **AFFIDAVIT:** I swear or affirm that all the information I have written on this form or told to a DHS specialist is true. I understand that I can be prosecuted for perjury if I have intentionally given false information. I also know that I may be asked to show proof of any information I have given. If I have intentionally left out any information or given false information which causes me to receive benefits I am not entitled to, or more benefits than I am entitled to, I understand that I can be prosecuted for fraud.
8. **RELEASE OF INFORMATION:** I authorize the Department to provide information to my child care provider(s) when CDC services have been authorized or when there are changes in the authorization information previously given to the provider or when my application for CDC is denied or withdrawn or my case is closed. I also authorize the Department or any child care provider that may provide care for my child(ren) to release information necessary to determine my right to benefits under any other local, state or federal program.
   I authorize the Social Security Administration to give to the Department all information necessary to determine my eligibility for CDC benefits.
9. **COMPUTER CROSS-CHECKING:** The Department will check with federal, state and private agencies to make sure the information you provide on this application is correct. The Department may check wages, income, assets, unemployment benefits, income tax refunds, Social Security benefits and numbers, immigration status, etc.

I UNDERSTAND THAT:

- If approved for CDC, I may only use child care services during the times that I, and all other parents/substitute parents in my home, are unavailable due to employment, high school completion classes, approved education and training activities and approved activities for a health or social condition.
- I am responsible for any child care costs not paid by the Department, including benefits which may have been authorized but for which I no longer qualify, based on a change in circumstances.
- I am not eligible for CDC benefits before the need exists or before the DHS local office receives my signed application.
- If a reported change results in a reduction in benefits, the reduction will be made as soon as administratively possible by the Department without advance notice.
- Child care must be provided in Michigan by either a licensed child care center, licensed group child care home, registered family child care home, an enrolled unlicensed provider who provides care in the home where the child lives or who is a grandparent, great-grandparent, aunt/great-aunt, uncle/great-uncle or sibling of the child and who provides the care in his/her home.
- I understand that my provider is considered self-employed and not employed by the Department. My provider receives a payment that is issued on my behalf by the Department.
- My application may be one of those chosen for a complete investigation, and a Department representative might call my home and might contact other people in order to verify my eligibility for assistance.
- If I choose an unlicensed provider, he or she will not be enrolled or will not receive payment if:
  - He/she, or any adult reported as living in the provider's home, is on the DHS central registry as a perpetrator on a substantiated Children's Protective Services case or has been charged or convicted of certain disqualifying crimes.
  - **He/she has not completed the Basic Training requirement. (Great Start to Quality Orientation). No care provided prior to the training date will be paid by the Department.**

I HAVE READ AND UNDERSTAND ALL PARTS OF THIS FORM. (If you have any questions, be sure to ask your DHS specialist.)

Signature of applicant or representative	Date of signature
Signature of DHS specialist	Date of signature

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.	This form is issued under authority of Public Act 280 of 1939. Completion of this form is voluntary. However, if it is not completed, your eligibility cannot be determined and you will not receive child care services.