



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

CONFIDENCE GROWS HERE

YMCA of Marquette County Early Childhood Development Program



Infant Toddler Care



Full Day and Part Time
Preschool



Three locations

YMCA Early Childhood Development Center Marquette

3052 Wright Street Marquette MI 49855

P 906.273.1121 **F** 906.227.9248

W ymcamqt.org

YMCA Early Childhood Development Center Kl Sawyer

411 Scorpion Street Gwinn MI 49841

P 906.372.4044 **F** 906.475.9666

W ymcamqt.org

COMING SOON - YMCA Early Childhood Development Center Ishpeming

700 East North Street Ishpeming MI 49849 **P** 906.273.1121



WELCOME

WE'RE BUILDING BRIGHT FUTURES

Kids are our future! Strengthening our communities and developing our youth are two very important works of the Y. We know that families are on the go today, and because of that we operate a Early Childhood Development Centers, providing quality care for your child based on our four values of caring, honesty, respect and responsibility. Here, children learn values and positive behaviors, and can explore their unique talents and interests, helping them realize their potential. That makes for confident kids today and contributing and engaged adults tomorrow.

At our child development centers we are here to make your kids feel welcome and to help them quickly realize this is a place where they belong and can be themselves...try new things...learn new skills...make new friends...and be a part of something great.

Our programs can be a powerful tool for personal growth. This is why we strive to offer the highest quality camps with the most diverse opportunities. We put a lot of effort into creating a fun, safe environment by carefully selecting staff through screenings, background checks, and thorough trainings (including first aid, CPR, risk management, character building etc.) Our staff are of the highest integrity, personal and spiritual maturity, and are enthusiastic about your children.

Our Marquette center is nationally accredited by the National Association for the Education of Young Children and licensed by the Michigan Department of Human Services. Our KI Sawyer center has a 5 star rating from the Michigan Great Start Collaborative and is licensed by the Michigan Department of Human Services.

I hope that you and your family will join us
Sincerely,



Cindy Basse
Early Childhood
Education Leader



Amber Ostlund
Early Childhood
Development Leader
- KI Sawyer

BUILDING BLOCKS

Infants Toddlers & Twos

Let's give them a great start! We think that the building blocks to a happy adulthood begin at the youngest age and we want to make sure that your child gets a chance to build relationships and develop their own personality, so they can grow up to be a secure and well-rounded adult. Our teachers know that children hit their milestones at their own pace, so we encourage each child to develop at their own pace. We meet or exceed the following ratios to ensure that every child gets the attention he or she needs.



Program takes place at our YMCA Early Childhood Development Center - Marquette & Ishpeming

JUST THE RIGHT CARE

Preschool

Our preschoolers discover science, arts, healthy habits, math, literacy and more! We know how fast children this age develop and that they want to explore everything, they can. Here they are the same children and teachers every day and build important relationships and friendships. With relationships as the foundation, preschoolers explore and discover important concepts in all developmental domains including social, emotional, and school readiness competencies. And all of this occurs in a fun, active child initiated environment.



Program takes place at our YMCA Early Childhood Development Center - Marquette, KI Sawyer & Ishpeming

BEFORE & AFTER SCHOOL

School Age

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!



Program takes place at our YMCA Early Childhood Development Center - KI Sawyer, & Birchview and Lakeveiw Schools

COME TAKE A GLIMPSE

Want to know more and take a glimpse inside? We invite you to come in for a visit! You will be able to tour our facilities, look at our classrooms, and meet the teachers. What better way is there to familiarize yourself with our Children's Center and to see what we can offer for your family?

BUILDING BLOCKS

Infants Toddlers & Twos

The YMCA is committed to providing a safe, loving and positive environment for infants and toddlers ages 1 month to 2.9 years. A focus is placed on flexible programming to match your child's developmental needs. All of our programs are licensed by the state and we follow the Department of Education's curriculum frameworks and strive to meet the social, emotional, cognitive and motor skill levels of each child.



CURRICULUM

We use the Creative Curriculum for Infants, Toddlers & Twos – a child based, emergent curriculum that uses the children's interest to create learning activities. The foundation of our curriculum is the building of relationships and secure bonds.

Each classrooms' daily schedule allows for an equal amount of activity and rest, as well as indoor and outdoor activities.

When planning activities, our teachers take into account every child's developmental history, family home values, beliefs, experiences, religion and language; teachers adapt their teaching methods accordingly throughout the year. We regularly keep our parents updated on their child's development, curriculum objectives and educational goals.



NUTRITION

The centers have adopted the Healthy Eating standards championed by the YMCA of the USA. HEPA (Healthy Eating and Physical Activity) standards encourage children to eat healthy and provide the food that supports proper cognitive and physical development.

We provide formula with iron, commercial baby food in jars and rice cereal for infants too young to eat the catered lunch.

We are sensitive to rise in number of children with dietary restrictions and work diligently to make sure every child is getting the nutrition needed for their growth and development. That's why we have an alternative vegetarian menu and available along with the option for organic milk or soy milk.

JUST THE RIGHT CARE

Preschool



CURRICULUM

The YMCA Early Childhood Program uses the Creative Curriculum, a widely respected early childhood curriculum based on early childhood theorists including Jean Piaget, John Dewey, Erik Erickson, Lev Vygotsky and Urie Bronfenbrenner. The Creative Curriculum guides teachers in providing a high quality, developmentally appropriate curriculum which supports growth and learning in all domains including language and literacy, social, emotional, cognitive including math and science, physical and creative.

Five fundamental principles of Creative Curriculum provide a framework and guide our teachers in the implementation of the Creative Curriculum. These principles recognize the importance of positive relationships between children and adults; the significance of social emotional competence in school success; the role constructive purposeful play and learning environments has in children's development; and the importance of family collaboration.



COMMUNITY CONNECTIONS

We believe that it is important to instill the feeling of belonging to our Marquette County community in each child. Our community is full of rich and diverse opportunities to teach children the value of their neighborhood and of those who live in it.

We achieve this by taking active walks in the community, visiting local community helpers, inviting guest speakers into the classroom and through field trips to local businesses and attractions.



NUTRITION

The centers have adopted the Healthy Eating standards championed by the YMCA of the USA. HEPA (Healthy Eating and Physical Activity) standards encourage children to eat healthy and provide the food that supports proper cognitive and physical development.

We serve children in our care breakfast, a morning snack, hot lunch and an afternoon snacks. We follow strict guidelines of food service and documentation of meals.

We are sensitive to rise in number of children with dietary restrictions and work diligently to make sure every child is getting the nutrition needed for their growth and development. That's why we have an alternative vegetarian menu and available along with the option for organic milk or soy milk.



OUR STAFF

Our primary caregivers and teaching staff have experience and education in early childhood education. Many have a long history and relationship with the Y.

The bond established between your child and their primary caregiver provides a sense of security that enhances learning.

Consistency, a stimulating environment, exceptional care and education is what every family receives at our centers.

BEFORE & AFTER SCHOOL

School Age

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!



BAS LOCATIONS



YMCA Early Childhood Development Center - KI Sawyer

Amber Ostlund
aostlund@ymcamqt.org
906.372.4044

HOURS

Monday - Friday
Before - 7:00am - 8:30am
After - 3:45pm - 6:00pm
Grades K - 5



Before & After School - Gilbert Elementary Location

Amber Ostlund
aostlund@ymcamqt.org
906.372.4044

HOURS

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



Before & After School- Birchview Location

Ben Platt
bplatt@ymcamqt.org
906.227.9622

HOURS

Monday - Friday
Before - 6:45am - 8:30am
After - 3:45pm - 6:00pm
Grades K-5



Before & After School - Lakeview Location

Ben Platt
bplatt@ymcamqt.org
906.227.9622

HOURS

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

Before & After School Rate
\$3.00 a day at all locations

YMCA Early Childhood Development Center – Marquette

Our YMCA Early Childhood Development Center – Marquette is a NAEYC accredited center and a Michigan licensed center. The National Association for the Education of Young Children (NAEYC) advocates for children through its national accreditation system developed in 1985 – the highest achievement an early childhood program can earn. Nationally accreditation is truly the highest mark of quality in the field of early childhood education. NAEYC provides well-defined criteria based on research and input from experts around the country; these criteria are divided into ten professional standards which define high quality in early childhood settings, birth through age eight.



Programs who achieve NAEYC accreditation must meet all ten program standards (NAEYC, 2015).



Hours

Full Day Monday: Friday, 7am – 6pm
 Half Day Morning: 8:30am – 12:30pm
 Half Day Afternoon: 12:30pm – 4:30pm

	Infant/Toddler Rate	Preschool Rate (Starting at 3 yrs of age)
Member Rate	Half Day: \$370/month Full Time: \$720/month Per Day: \$43 Extended Care: \$5/hour	Half Day: \$290/month Full Time: \$560/month Per Day: \$33 Extended Care: \$3.50/hour
Non Member Rate	Half Day: \$420/month Full Time: \$820/month Per Day: \$46 Extended Care: \$5.25/hour Minimum 2 full days with consistent schedule	Half Day: \$318/month Full Time: \$615/month Per Day: \$36 Extended Care: \$3.75/hour Minimum 2 full days with consistent schedule

DHS Subsidy Accepted

Registration Fee: \$25.00 per Child

Late Pick Up Fee: \$20.00 Per Each 15 minutes after 6:00 pm

Late Payment or Insufficient Funds Fee: \$25.00

For more information contact

Cidny Basse Child Development Leader,
 YMCA Early Childhood Development – Marquette
 3052 Wright Street, Marquette MI 49855
 P 906.372.4044 E aostlund@ymcamqt.org



Our YMCA Early Childhood Development Center – KI Sawyer Center has been awarded the highest rating possible (five stars) by the State of Michigan for our quality preschool program. We are a proud partner and participant of the Great Start Readiness Program, which provides tuition assistance for qualifying families to enroll their four-year-old in an affordable, high quality program.

Our 5-star preschool program is licensed by the State of Michigan and promote the physical, social, emotional, and cognitive development of your child and responds to the needs of the entire family. Our curriculum offer a hands-on learning environment that encompasses both fine and gross motor skills along with preparing the children for kindergarten.



Hours

Full Day Monday: Friday, 8am – 4pm

Half Day Morning: 8am – 12pm

Half Day Afternoon: 12pm – 4pm

Extended Day Care (before 8am or after 4pm): \$3.50/hour

Preschool Rate (Starting at 2 ½ yrs of age)

\$17/half day

\$33/full day

Before & After School Age Rate

\$3/day

Days off Program Rate

\$10/day

Minimum 2 full days with consistent schedule

DHS Subsidy Accepted

Registration Fee: \$10.00 per Child

Late Pick Up Fee: \$20.00 Per Each 15 minutes after 6:00pm

Late Payment or Insufficient Funds Fee: \$25.00



For more information contact

Amber Ostlund, Child Development Leader,
YMCA of Marquette County – KI Sawyer
411 Scorpion Street, Gwinn MI 49841
P 906.372.4044 E aostlund@ymcamqt.org

DHS

We accept DHS payment for families who qualify for child care assistance through Marquette County’s Department of Human services. If you are already part of the MI Bridges you can fill out the Child Development and Care Application on page **21 - 26** and turn it into the DHS office.

COMMITTED TO OUR COMMUNITY

Determining assistance amounts is handled by the YMCA in a fair and consistent manner. Every YMCA member receives the same membership benefits, regardless of whether or not they receive financial assistance. YMCA members can feel confident knowing that they are a part of an organization that cares greatly for the well-being of all people, and is committed to youth development, healthy living and social responsibility.

HOW TO REGISTER

Complete the registration forms. Please fill out information on EVERY line clearly. Incomplete registration forms will not be accepted (immunization information is required).

Drop off your completed registration form and payment information to either location:

YMCA Early Childhood Development Center - Marquette
3052 Wright Street, Marquette, MI 49855

YMCA Early Childhood Development Center - KI Sawyer
411 Scorpion Street, Gwinn, MI 49841

YMCA Early Childhood Development Center - Ishpeming
700 East North Street, Ishpeming, MI 49866

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: _____ ☐  ☐  ☐  ☐ 

CID#: _____ Signature: _____

Today’s Date: _____ Staff initials: _____

PAYMENT INFORMATION

Balance is due the 1st and 3rd Friday of each month, which is made by automatic draft either by credit/debit form or voided check.



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

PARTICIPANT INFORMATION

Participant's Name _____

Address _____

City _____ **State** _____ **Zip Code** _____

Telephone Number _____ **Date of Birth** ____/____/____ **Sex** **M** **F**

Parent or Guardian Name _____

Address (if different from above) _____

Cell/ Page Number _____ **Work Number** _____

Parent or Guardian _____

Address (if different from above) _____

Telephone Number _____ **Work Number** _____

Emergency Contact (if parent/ guardian is not available) _____

Telephone Number _____ **Relationship** _____

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: _____

Classroom use only ☐

No Photos ☐

FIELD TRIP CONSENT

I give my consent for my child's participation in any walking and/or vehicular field trips as scheduled during program operating hours. I understand that details will be sent home to me in advance and/or posted on the parent information board, and that these trips are dependent on daily weather conditions.

Parent's Signature: _____ Date: _____

SUNSCREEN RELEASE

Coopertone Babies SPF 30 is provided by the YMCA for a fee. The **ingredients** for this sunscreen are Aloe Barbadensis Leaf Juice, Carbomer, Cetyl Alcohol, Cholecalciferol (Vitamin D), DEA-Cetyl Phosphate, DMDM Hydantoin (and) Iodopropynyl Butylcarbamate, Hydrogenated Polybutene, Retinyl Palmitate (Vitamin A), Stearic Acid, Tocopheryl Acetate (Vitamin E), Triethanolamine, Water with **Active Ingredients** being Ethylhexyl p-Methoxycinnamate (Octinoxate), 2-Ethylhexyl Salicylate (Octisalate) Oxybenzone, Homosalate.

- ☐ Having reviewed the provided ingredient list, I do not know of any allergies or allergic reactions my child may have to Rocky Mountain Sunscreen (SPF 30) and **give permission** for staff to apply it 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.

We will be charging a one-time fee of \$15.00 for the summer 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.

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: _____

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 its equipment or facilities, and my (my child's) participation in its activities, whether on its premises or at another location, and for myself and my heirs and assigns to hereby waive, release and agree to hold free 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 outlined in the YMCA Early Childhood Development Center Parent Handbook found in the right pocket of your enrollment folder.

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 extent allowed by law.

Parent's Signature: _____

Date: _____

ASQ 3 CONSENT FORM

The first 5 years of life are very important for your child because this time sets the stage for success in school and later life. During infancy and early childhood, your child will gain many experiences and learn many skills. It is important to ensure that each child's development proceeds well during this period.

Please read the text below and mark the desired space to indicate whether you will participate in the screening/monitoring program.

I have read the information provided about the Ages and Stages Questionnaires®, Third Edition (ASQ-3™), and I wish to have my child participate in the screening/monitoring program. I will fill out questionnaires about my child's development and will promptly return the completed questionnaires.

I do not wish to participate in the screening/monitoring program. I have read the provided information about the and Stages Questionnaires®, Third Edition (ASQ-3™), and understand the purpose of this program.

Signature _____ Date ____/____/____

If child was born 3 or more weeks prematurely, # of weeks premature: _____

Child's primary physician: _____

NEW FAMILY SURVEY

Who is part of your child's family? Include names, ages and relationship to child; don't forget pets!

What does your child like to do for fun? Are there activities he/she dislikes?

Are there behavior issues we should be aware of? If so, what strategies have been successful for you?

How does your child handle routine separation and/or transitions?

How do you soothe your child?

Tell us about your child's sleep habits. Does he/she sleep well at night? Does he/she take a nap?

Do you have any skills, activities or traditions you are willing to share with the children in our program?

What language does your family speak at home? _____

Does your family celebrate holidays and special occasions? Which ones? How do you celebrate?

Do you have any concerns about your child's development? Does your child have any special needs (environmental, nutritional, etc)? _____

What are your goals for your child in our program?

Is there other information about your child you would like to share with us right now (sensitivities, fears, etc.)? _____

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.

HEALTH APPRAISAL

Dear Parent or Guardian: The following information is requested so that the school can work with the parent to meet the physical, intellectual and emotional needs of the child. Fill out the information requested in Section I. Section III may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse and dentist. **(BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION.)**

PERSONAL

CHILD'S NAME (Last, First, Middle)			DATE OF BIRTH (mm/dd/yy) / /
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	TODAY'S DATE (mm/dd/yy) / /
PARENT/GUARDIAN (Last, First, Middle)			HOME TELEPHONE NUMBER ()
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	WORK TELEPHONE NUMBER ()

SECTION I - HEALTH HISTORY

Yes	No	Resolved	# Is your child having any of the problems listed below?	Birth History:
☐	☐	☐	1 Allergies or Reactions (for example, food, medication or other)	
☐	☐	☐	2 Hay Fever, Asthma, or Wheezing	
☐	☐	☐	3 Exzema or Frequent Skin Rashes	
☐	☐	☐	4 Convulsions/Seizures	
☐	☐	☐	5 Heart Trouble	
☐	☐	☐	6 Diabetes	
☐	☐	☐	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)	
☐	☐	☐	8 Trouble with Passing Urine or Bowel Movements	
☐	☐	☐	9 Shortness of Breath	
☐	☐	☐	10 Speech Problems	
☐	☐	☐	11 Menstrual Problems	
☐	☐	☐	12 Dental Problems: Date of Last Exam / /	
☐	☐	☐	Other (please describe): _____	
☐	☐	☐	Does your child take any medication(s) regularly?	Are there any current or past diagnosis(es) ☐ Yes ☐ No
Reason for Medication _____				If yes, please describe: _____
_____ / /				
Parent/Guardian Signature _____ Date _____				
				If yes, list medications: _____
				Was the health history reviewed by a health professional?
				☐ Yes ☐ No Examiner's Initials: _____

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care	No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	VISION Date: / /	Visual Acuity Muscle Imbalance Other: _____				☐	☐	HEIGHT & WEIGHT Other: _____	Height Weight Other: _____			
☐	☐	HEARING Date: / /	Audiometer Other: _____				☐	☐	HEMOGLOBIN / HEMATOCRIT				
☐	☐	URINALYSIS Date: / /	Sugar Albumin Microscopic				☐	☐	BLOOD PRESSURE	Reading: _____			
☐	☐	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl				☐	☐	TUBERCULIN	Type: _____ Neg.: ☐ Pos.: ☐ _____ mm			

NOTE: Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above.

Examinations and/or Inspections

Essential Findings Deviating from Normal:
Exam Date: / /

SECTION III - IMMUNIZATIONS

Statements such as "UP TO DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.*

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY		VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (Hep B)	1	3	Hepatitis A (Hep A)	1	2
	2		Influenza TIV/LAIV	1	3
				2	4
DTaP/DTP/DT/Td	1	4	Meningococcal MCV4 / MPSV4	1	2
	2	5			
	3	6	Human Papillomavirus (HPV4/HPV2)	1	2
Tdap	1			2	3
Haemophilus Influenzae type b (HIB)	1	3	OTHER Vaccines	Type of Vaccine(s)	Date of Vaccine(s)
	2	4		1	
Polio - IPV / OPV	1	3	Specify Date & Type	2	
	2	4		3	
Pneumococcal Conjugate (PCV7/PCV13)	1	3	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable		
	2	4	*NOTE: According to Public Act 368 of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious and other objections, provided that the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your child's school or local health department.		
Rotavirus (RV1/RV5)	1	3	Parent/Guardian refused immunizations: ☐		
	2				
Measles, Mumps, Rubella (MMR)	1	2			
Varicella (Chickenpox)	1	2			
History of Chickenpox Disease? ☐ Yes ☐ No If yes, date: _____					
I certify that the immunization dates are true to the best of my knowledge					
_____ Health Professional's Signature			_____ Title		_____ Date

SECTION IV - RECOMMENDATIONS

(Required for Child Care and Head Start/Early Head Start)

No	Yes	
☐	☐	Is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain:
☐	☐	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): ☐ Classroom ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ Other
Other Recommendations		

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined _____ child's name _____'s teeth. As a result of this examination, my recommendation for treatment is: _____

Dentist's Signature

Date

PHYSICIAN'S SIGNATURE

_____ Examiner's Signature	_____ Date	_____ Examiner's Name (Print or Type)	_____ Degree or License
_____ Number & Street	_____ City	_____ MI	_____ ZIP Code
		_____ Telephone	

Information required for:

Early On - Hearing and Vision Status; Diagnosis; Health Status

Child Care Licensing - Physical Exam, Restrictions, Immunizations

Head Start/Early Head Start - Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the schedule of well-child care required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia and regular intervals based on age.

Developed in Cooperation with the Departments of Human Services, Education, Community Health, Michigan American Association of Pediatrics, Early Childhood Investment Corporation, Child Care Licensing, Head Start, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons.

Child & Adult Care Food Program –

Our YMCA Early Childhood Development Centers offers healthy meals 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 (HIES). In addition, by filling out this form, we will be able to determine if your child(ren) qualifies for free or reduced price meals.

- Do I need to fill out a HIES 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: **YMCA Early Childhood Development Center – Marquette, 3052 Wright Street, Marquette MI 49855 or YMCA Early Childhood Development Center – KI Sawyer, 411 Scorpion St, Gwin, MI 49841.**
- **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 are also eligible for free meals.
- **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, 2013, until June 30, 2014, shown below:

Family Size	Yearly Income	Monthly Income
1	\$21,257	\$1,772
2	\$28,694	\$2,392
3	\$36,131	\$3,011
4	\$43,568	\$3,631
For each additional family member add:	\$7,437	\$620

Refer to the Instructions for Parents/Guardians Household Income Eligibility Statement on how to complete the HIES. Find the category that most closely defines your household and follow the directions for completing each part of the HIES. 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 HIES.

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.

Your family may be eligible to receive Women, Infants & Children (WIC), a health and nutrition program, that has demonstrated a positive effect on pregnancy outcomes, child growth, and development. To determine eligibility, call 1-800-26-BIRTH or access online information at www.michigan.gov/wic to learn about WIC and locate a local WIC agency.

- **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.

- **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.
- **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.
- **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.
- **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 HIES, but are not required to include payments received for the foster child as income.
- **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, the U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

Household Income Eligibility Statement

If any member of your

Name: _____

Case Number:

[illegible]

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.

Date: _____

☐ I do not have a Social Security number

For Institution Use Only

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

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."

STOP HERE
Unless you are eligible for 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 (<i>First, middle, last</i>)		2. Former/maiden name		3. Marital status ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	
4. Authorized representative name (<i>First, middle, last</i>)			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	
14. Phone number where we can leave a message		Whose is it? (name/relationship)			13. TTY #
15. Email address					
16. Ethnicity (optional) ☐ Hispanic/Latino ☐ Non-Hispanic/Latino		17. Race (optional) ☐ American Indian/Alaska Native – Enter tribe name _____ ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White			
18. I need child care services for (<i>Check all that apply.</i>) ☐ Work ☐ High School or GED Completion ☐ Approved Education/Training/Employment Preparation ☐ Treatment for Health or Social Condition (explain): _____			19. I need study time for (<i>Check all that apply.</i>) ☐ High School or GED Completion ☐ Approved Education/Training/Employment Preparation		
			Number of weekly hours _____		

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? ☐ No ☐ Yes	If the child does not live with a parent, who does the child live with and the relationship to the child? Name _____ Relationship _____	If parent not in the home, ☒ proper box.							Parent's mailing address if different from the applicant.	Does the parent provide child support? ☐ No ☐ Yes If yes, provide support # if known _____
				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 Mon _____ Tue _____ Wed _____ Thur _____ Fri _____ Sat _____	Gross monthly income (amount before any expenses) \$ _____	Date of most recent or last pay check
Self-employed person	Start date	Business name/address/ phone number	Type of work	Hours of self-employment Mon _____ Tue _____ Wed _____ Thur _____ Fri _____ Sat _____	Gross monthly income (amount before any expenses) \$ _____	Date of most recent or last pay check

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 ▶

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.
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