



FOR OFFICE USE ONLY	
Date Received:	_____
Received By:	_____

# CAMP HENRY APPLICATION

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## CAMPER INFORMATION

☐ Returning Camper ☐ New Camper

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ ☐ Male ☐ Female

Camper Cell Phone: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Sibling attending camp: \_\_\_\_\_ Current School: \_\_\_\_\_

Grade as of September 2019: \_\_\_\_\_ OSIS #: \_\_\_\_\_

What languages are spoken in the camper's home? \_\_\_\_\_

## PARENT/GUARDIAN INFORMATION

**Primary Guardian** Please note that the person filling out this registration form is considered the Primary Guardian and is the only one authorized to make changes to the application. Should such changes be necessary, they are to be done in writing only by the Primary Guardian.

Name: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Primary Language Spoken: \_\_\_\_\_

Employer (if unemployed, write "None"): \_\_\_\_\_

Job/Position: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### Secondary Guardian

Name: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Primary Language Spoken: \_\_\_\_\_

Employer (if unemployed, write "None"): \_\_\_\_\_

Job/Position: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Is the above person authorized to pick up my child at the end of each day or in the event of an emergency?

☐ Yes

☐ No

**Camper Name:** \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION

The first attempt will be made to contact the camper's parents/guardians. Emergency Contacts listed below must be a maximum of 20 minutes away from Henry Street Settlement and be able to pick your child up in the event of an emergency. Please notify us immediately through writing if this information changes over the course of the summer.

### Emergency Contact 1

Name: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Primary Language Spoken: \_\_\_\_\_

Is the above person authorized to pick up my child at the end of each day or in the event of an emergency?

☐ Yes ☐ No

### Emergency Contact 2

Name: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Primary Language Spoken: \_\_\_\_\_

Is the above person authorized to pick up my child at the end of each day or in the event of an emergency?

☐ Yes ☐ No

### Emergency Contact 3

Name: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Primary Language Spoken: \_\_\_\_\_

Is the above person authorized to pick up my child at the end of each day or in the event of an emergency?

☐ Yes ☐ No

## GENERAL INFORMATION

How did you find out about Camp Henry? ☐ Facebook ☐ Twitter ☐ Instagram

☐ Other (Please specify): \_\_\_\_\_

Has the camper previously participated in a Henry Street Settlement Program? ☐ Yes ☐ No

If yes, what program(s)? \_\_\_\_\_

## CAMP HENRY RULES ON DROP OFF & PICK UP

A camper 12 years of age and older will be able to be dismissed from Camp Henry on their own and escort any younger siblings home **ONLY** if Camp Henry is given written permission from the primary/custodial guardian. Campers 12 years and older will not be allowed to escort non family members home, nor will they be able to leave camp until the general camp dismissal time.

For all other children, only a parent or guardian or sibling that is **18 years of age or over** may pick them up and escort them home.

If your child is under 12 years of age, they cannot be dropped off and expected to sign themselves in. The sign-in sheet is not allowed to be brought out to you. All campers must be signed in by a parent, guardian, or sibling that is listed on registration. You may add names, but only in writing via a camp director or camp registrar.

Please be advised that you will not be able to drop off your child after the designated check in time. The participants move throughout the neighborhood and the boroughs and we will be unable to accommodate those who arrive late because students will already be fully engaged in activities or travel.

Participants are not allowed to be picked up early except in the instances of emergencies. Even then, your child might not be in the 301 building or they may be involved in an activity that cannot be interrupted. Please be patient while we accommodate you.

### Please Check One:

- ☐ I hereby give my child, who is at least 12 years old, permission to go home unescorted.
- ☐ I do not give my child, who is at least 12 years old, permission to go home unescorted.
- ☐ I hereby give my child, who is at least 12 years old and is a camper at Camp Henry, permission to escort his/her younger sibling(s) home.

Camper Name: \_\_\_\_\_

IMPORTANT CHECK-OFF ITEMS

Please list ALL allergies your child may have, no matter how mild:

\_\_\_\_\_

\_\_\_\_\_

Please list any food restrictions your child may have for cultural, religious or medical reasons:

\_\_\_\_\_

\_\_\_\_\_

Check off your child’s aquatic skill level (all that apply):

- ☐ Doesn’t know how to swim      ☐ Doggy Paddle      ☐ Float      ☐ Swim

Check off your child’s t-shirt size:

- Child: ☐ S   ☐ M   ☐ L   ☐ XL      Adult: ☐ S   ☐ M   ☐ L   ☐ XL   ☐ XXL

PLEASE INITIAL EACH STATEMENT

_____	A deposit of \$100 must accompany this application. The deposit is for registration and is <b>NON REFUNDABLE. The tuition payment is due in full no later than June 21.</b> After June 21. only 50% of paid tuition is refundable if you withdraw by the mentioned date. No child will be permitted to attend camp without payment in full by the above-mentioned date. Money orders should be made out to Henry Street Settlement or we accept Visa, MasterCard, or Discover credit cards.
_____	No child will be properly enrolled in Camp Henry for the 2019 summer without the following paperwork <b>FULLY</b> completed by <b>JUNE 21, 2019: I understand that my child(ren) will not be able to attend camp unless the following items are on file:</b> <ul style="list-style-type: none"><li>• Fully completed camp application</li><li>• Accurate and up to date medical form</li><li>• Copies of their signed immunization record</li><li>• Current insurance card</li></ul>
_____	If child does not attend camp, the entire fee paid to date of this notice will be forfeited. <b>No refund</b> will be granted if the camper leaves on his/her own account or is removed from camp due to an inability to adjust or to comply with the camp rules or is unable to function adequately. <b>There is no reduction/ refund based on missed days due to absence, illness or to early withdrawal.</b>
_____	I am aware that my child must follow the rules and regulations of the summer camp program and may be terminated from Camp Henry if he or she does not comply.
_____	I hereby consent to the taking of photographs, movies, internet use, and videotapes, of my child by Henry Street Settlement or its designated representatives. I also grant the right to edit, use, and re-use said products for any and all educational, public service, or not for profit purposes selected by Henry Street Settlement and release any and all rights, title, and interest we or the child may have in said products. Photocopies and facsimiles of this release and consent shall have the same legal effect as the original.
_____	I understand that I, or a designated family member, must attend a camp orientation in order to complete my registration process.
_____	Camp Henry is not responsible for any personal items (cell phones, hand-held devices, toys) that are lost, stolen and/or damaged while attending camp.
_____	If there is an emergency that requires me to pick my child up early from camp, I understand that I am expected to contact the camp office immediately to give them as much time as possible to accommodate us.

\_\_\_\_\_ If your child has a cell phone on them, it will not be activated during camp hours.

\_\_\_\_\_ I consent that in an emergency Henry Street Settlement may act in loco parentis and obtain medical treatment if necessary. I understand that if medical treatment is deemed necessary I will be informed as soon as possible.

\_\_\_\_\_ I give my permission for Henry Street Settlement staff to take my child on walking field trips as a part of their summer day camp activities. This includes, but is not limited to, neighborhood parks, Abrons Arts Center, events at other public spaces, camp programs at 301 Henry Street, Boys & Girls Republic, P.S. 20, etc. I understand that for any field trip involving transportation, I will receive a permission slip specific to that particular trip.

**Camper Name:** \_\_\_\_\_

**I reviewed the application and all the information provided is accurate and true. I agree to all the terms and conditions.**

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**How did you hear about Camp Henry?**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Returning camper | <input type="checkbox"/> Henry Street Settlement | <input type="checkbox"/> In the community |
| <input type="checkbox"/> Red Tricycle     | <input type="checkbox"/> Big Apple Parent        | <input type="checkbox"/> The LoDown       |
| <input type="checkbox"/> Other: _____     |  |   |

**Please return completed application, medical form, and CACFP Form  
(found on the next 3 pages) to: **Attn: Camp Services**  
**Henry Street Settlement**  
**301 Henry Street, 3<sup>rd</sup> Floor**  
**New York, NY 10002****

# CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please  
Print Clearly  
Press Hard

STUDENT ID NUMBER  
OSIS

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## TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name		First Name		Middle Name		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (Month/Day/Year) ____/____/____
Child's Address				Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	Race (Check ALL that apply) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other		
City/Borough		State	Zip Code	School/Center/Camp Name		District Number ____	Phone Numbers Home _____ Cell _____ Work _____
Health insurance (including Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No		Parent/Guardian <input type="checkbox"/> Parent/Guardian Last Name <input type="checkbox"/> Foster Parent		First Name			

## TO BE COMPLETED BY HEALTH CARE PROVIDER If "yes" to any item, please explain (attach addendum, if needed)

<b>Birth history</b> (age 0-6 yrs) <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____ <b>Allergies</b> <input type="checkbox"/> None <input type="checkbox"/> Epi pen prescribed <input type="checkbox"/> Drugs (list) _____ <input type="checkbox"/> Foods (list) _____ <input type="checkbox"/> Other (list) _____		<b>Does the child/adolescent have a past or present medical history of the following?</b> <input type="checkbox"/> Asthma (check severity and attach MAF/Asthma Action Plan): <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent If persistent, check all current medication(s): <input type="checkbox"/> Inhaled corticosteroid <input type="checkbox"/> Other controller <input type="checkbox"/> Quick relief med <input type="checkbox"/> Oral steroid <input type="checkbox"/> None <input type="checkbox"/> Attention Deficit Hyperactivity Disorder <input type="checkbox"/> Orthopedic injury/disability <input type="checkbox"/> Chronic or recurrent otitis media <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Other (specify) _____		<b>Medications</b> (attach MAF if in-school medication needed) <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____ _____ <b>Dietary Restrictions</b> <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____	
Explain all checked items above or on addendum					

### PHYSICAL EXAMINATION

Height \_\_\_\_\_ cm (\_\_\_\_ %ile)  
 Weight \_\_\_\_\_ kg (\_\_\_\_ %ile)  
 BMI \_\_\_\_\_ kg/m<sup>2</sup> (\_\_\_\_ %ile)  
 Head Circumference (age ≤2 yrs) \_\_\_\_\_ cm (\_\_\_\_ %ile)  
 Blood Pressure (age ≥3 yrs) \_\_\_\_\_ / \_\_\_\_\_

### General Appearance:

NI Abnl	HEENT	NI Abnl	Lymph nodes	NI Abnl	Abdomen	NI Abnl	Skin	NI Abnl	Psychosocial Development
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Dental	<input type="checkbox"/>	<input type="checkbox"/> Lungs	<input type="checkbox"/>	<input type="checkbox"/> Genitourinary	<input type="checkbox"/>	<input type="checkbox"/> Neurological	<input type="checkbox"/>	<input type="checkbox"/> Language
<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/> Extremities	<input type="checkbox"/>	<input type="checkbox"/> Back/spine	<input type="checkbox"/>	<input type="checkbox"/> Behavioral

### Describe abnormalities:

<b>DEVELOPMENTAL</b> (age 0-6 yrs) <input type="checkbox"/> Within normal limits If delay suspected, specify below <input type="checkbox"/> Cognitive (e.g., play skills) _____ <input type="checkbox"/> Communication/Language _____ <input type="checkbox"/> Social/Emotional _____ <input type="checkbox"/> Adaptive/Self-Help _____ <input type="checkbox"/> Motor _____	<b>SCREENING TESTS</b>		<b>Date Done</b>		<b>Results</b>		
	<b>Blood Lead Level (BLL)</b> (required at age 1 yr and 2 yrs and for those at risk)		____/____/____		_____ µg/dL		
	<b>Lead Risk Assessment</b> (annually, age 6 mo-6 yrs)		____/____/____		<input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk		
	<b>Hearing</b> <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE		____/____/____		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
<b>Hemoglobin or Hematocrit</b> (age 9-12 mo)		<b>Head Start Only</b>		____/____/____		_____ g/dL _____ %	
<b>Tuberculosis</b> Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school							
<b>PPD/Mantoux placed</b>		____/____/____		<b>Induration</b> _____ mm		<b>PPD/Mantoux read</b>	
____/____/____		____/____/____		<input type="checkbox"/> Neg <input type="checkbox"/> Pos		<b>Interferon Test</b>	
____/____/____		____/____/____		<input type="checkbox"/> Neg <input type="checkbox"/> Pos		<b>Chest x-ray</b> (if PPD or Interferon positive)	
____/____/____		____/____/____		<input type="checkbox"/> NI <input type="checkbox"/> Not <input type="checkbox"/> Abnl Indicated		<b>Vision</b> (required for new school entrants and children age 4-7 yrs)	
____/____/____		____/____/____		<input type="checkbox"/> with glasses		<b>Acuity</b> Right ____ / ____ Left ____ / ____ Strabismus <input type="checkbox"/> No <input type="checkbox"/> Yes	

### IMMUNIZATIONS – DATES

CIR Number  
of Child

--	--	--	--	--	--	--	--

Hep B \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Rotavirus \_\_\_\_/\_\_\_\_/\_\_\_\_  
 DTP/DTaP/DT \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Hib \_\_\_\_/\_\_\_\_/\_\_\_\_  
 PCV \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Polio \_\_\_\_/\_\_\_\_/\_\_\_\_

Influenza \_\_\_\_/\_\_\_\_/\_\_\_\_  
 MMR \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Varicella \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Td \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Tdap \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Meningococcal \_\_\_\_/\_\_\_\_/\_\_\_\_  
 HPV \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Other, Specify: \_\_\_\_/\_\_\_\_/\_\_\_\_; \_\_\_\_/\_\_\_\_/\_\_\_\_

### RECOMMENDATIONS

☐ Full physical activity ☐ Full diet

☐ Restrictions (specify) \_\_\_\_\_  
**Follow-up Needed** ☐ No ☐ Yes, for \_\_\_\_\_ Appt. date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Referral(s):** ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision  
☐ Other \_\_\_\_\_

### ASSESSMENT

☐ Well Child (V20.2) ☐ Diagnoses/Problems (list)

ICD-9 Code

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Health Care Provider Signature		Date ____/____/____	DOHMH PROVIDER ONLY I.D. _____
Health Care Provider Name and Degree (print)		Provider License No. and State	TYPE OF EXAM: <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s)
Facility Name		National Provider Identifier (NPI)	Comments
Address		City	Date Reviewed: ____/____/____
Telephone (____) _____ - _____		Fax (____) _____ - _____	I.D. NUMBER ____/____/____
			REVIEWER:

See INSTRUCTIONS on reverse.

**CHILD CARE CENTER NAME** \_\_\_\_\_

Print the name of the child(ren) enrolled in this child care center

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**DIRECTIONS**

**Complete SECTION A if anyone in your household**

1. Participates in the Supplemental Nutrition Assistance Program (SNAP)
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR) OR
4. Is a foster child

**SECTION A**

SNAP Case # \_\_\_\_\_

TANF # \_\_\_\_\_

FDPIR # \_\_\_\_\_

Names of \_\_\_\_\_  
Foster Children \_\_\_\_\_

**An adult household member must sign the application before it can be approved.** After reading the following statement and the statement on the back, sign below.

I certify that the above information is true. I understand that the center will get Federal funds based on the information I give.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**FOR SPONSOR USE ONLY**

CACFP Agreement # \_\_\_\_\_

Total Number of Household Members \_\_\_\_\_  
(INCLUDING FOSTER CHILDREN, IF APPLICABLE)

Total Household Income \$ \_\_\_\_\_

Free \_\_\_\_\_ Reduced \_\_\_\_\_ Paid \_\_\_\_\_

Date of Determination \_\_\_\_\_

Signature of \_\_\_\_\_  
Center Staff \_\_\_\_\_

**Complete SECTION B if no one in your household** participates in SNAP, receives TANF, participates in FDPIR or if none of the children enrolled in the child care center is a foster child.

**SECTION B**

List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received **last month** in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, child support, foster child's personal income and any other sources of income.

HOUSEHOLD MEMBER NAME	MONTHLY GROSS SALARY
1. _____	\$ _____
2. _____	\$ _____
3. _____	\$ _____
4. _____	\$ _____
5. _____	\$ _____
6. _____	\$ _____
7. _____	\$ _____

**An adult household member must sign the application before it can be approved.** After reading the following statement and the statement on the back, sign below.

I certify that the above information is true and that all income is reported. I understand that the center will get Federal funds based on the information I give.

Signature \_\_\_\_\_

Print Name \_\_\_\_\_

LAST FOUR (4) DIGITS OF  
SOCIAL SECURITY NUMBER

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DATE \_\_\_\_\_

USDA is an equal opportunity provider and employer.

**Privacy Act Statement:** The Richard B. Russell National School Lunch Act requires the information on this form. 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 form. The Social Security Number is not required when you: apply on behalf of a foster child; provide a SNAP, TANF or FDPIR number; or when you indicate that the adult household member signing the form does not have a Social Security Number. We will use your information to determine if the center is eligible for free or reduced-price meal reimbursement and for administration and enforcement of the Program.

### **INSTRUCTIONS FOR COMPLETING DOH-3688**

#### **Definition of Income**

*Income* means income before deductions for income taxes, social security taxes, insurance premiums, charitable contributions, and bonds, etc. It includes the following: (1) monetary compensation for services, including wages, salary, commissions or fees; (2) net income from non-farm self-employment; (3) net income from farm self-employment; (4) Social Security payments; (5) dividends or interest on savings or bonds, income from estates or trusts or net rental income; (6) unemployment compensation; (7) government civilian employee or military retirement, or pensions or veteran's payments; (8) private pensions or annuities; (9) alimony or child support payments; (10) regular contributions from persons not living in the household; (11) net royalties; (12) military benefits received in cash, such as housing allowance except if you are in the Military Housing Privatization Initiative; and (13) any other cash income.

#### **Definition of Household**

Household means *family* as defined in Section 226.2. *Family* means a group of related or non-related individuals who are not residents of an institution or boarding house, but who are living as one economic unit.

#### **INSTRUCTIONS FOR PARENTS OR GUARDIANS**

Write in the name of the child care center in the space provided.

Print the name of each child in your household who attends this child care center.

**Section A:** If anyone in your household participates in the Supplemental Nutrition Assistance Program (SNAP), receives Temporary Assistance for Needy Families (TANF) or participates in the Food Distribution Program on Indian Reservations (FDPIR), complete Section A only. Write down the SNAP, TANF or FDPIR number (do not use your ACS or DSS child care subsidy number). Then sign and date the form and return it to the day care center.

**Foster children:** If your household includes a foster child who is in child care, write in the names of the foster children.

**Section B:** Complete this section if you did not complete Section A. Write in your name and the names of all other adults and children living in the household, including unrelated people, even if they do not have any income. Do not include the children in child care who are listed at the top of the form.

Enter the amount of income each person received **last month**, before taxes or anything else was taken out. Refer to the Definition of Income and the Definition of Household, above. If any amount last month was more or less than the usual, write in that person's usual income.

The last four digits of the Social Security Number of the adult signing the certification is required. If you do not have a Social Security Number, write *none*. The form must be signed by an adult member of the household.

#### **INSTRUCTIONS FOR CENTERS AND SPONSORS**

**The For Sponsor Use Only section is to be completed, signed and dated by center or sponsor staff.** The sponsor/center representative must review the income eligibility form and ensure that it is completed as indicated in the instructions above. Then indicate the following:

##### **The CACFP Agreement Number.**

**Total Number of Household Members** – This item does not have to be completed if the parent completed Section A. Add those indicated in Section B (if completed) to the children enrolled in child care and the number of foster children, if applicable.

**Total Household Income** – This item does not need to be completed if the parent completed Section A. Indicate the total monthly income as calculated from Section B. If the parent chooses not to disclose income, the form must be categorized as *paid*.

**Number of Free, Reduced or Paid** – Compare the total household income and the total number of household members with the current year's Income Eligibility Guidelines (CACFP-3687) to determine if the household should be categorized as **Free, Reduced or Paid**. Use the appropriate column on the CACFP-3687 to categorize their income. For example, if the parent indicated biweekly income, multiply this amount by 26 to determine yearly income.

Incomplete forms (missing signatures, income information, last four digits of Social Security Number or SNAP, TANF or FDPIR numbers) are categorized in the paid category.

**The income eligibility form is valid until the last day of the month one calendar year from the date it is signed by the household member.** For example, a form signed on May 12, 2014 is valid until May 31, 2015.