



**Fort Knox Child, Youth & School Services (CYSS)  
Parent Central Services**

**Registration and Sign ups- Monday-Friday 0800-1600**

**Walk-in Registration 0900-1200~ Appointments 1300-1500**

**~Parent Central Services is closed 3<sup>rd</sup> Thursday afternoon of each month~**

*To expedite your CYSS registration process, please have the following information available.*

**Proof of Child Eligibility** (i.e. Legal Guardianship papers or Child Military ID Card)

**Sponsor's Social Security Number** (Needed for Child Care Tax Credit, USDA funding)

**Parent(s) Home and Work Information** (Need street address, mailing address [if different], military unit or employer name, primary/alternate phone numbers)

**Email Addresses** (Need AKO email address)

**Proof of Parent(s) Income** (i.e. Leave & Earnings Statements / Pay Vouchers. If spouse is full time student, bring proof of school enrollment) [Needed to determine DOD Fee Category for child care/school age fees]

**Two local Emergency and Child Release designees** – (names, address, and phone numbers)

**Family Care Plan Short-Term Release Designee** (Required for single/dual military and single/dual deployable civilian families) [Name, address, phone numbers of designee due within 30 days of registration]

**Child's Official Shot Record**

**Deployment Orders** (Families of deployed individuals can obtain Army Family Covenant discounts and benefits with proof of deployment)

- All FORMS Must be completed to use Services Before/After/During Visit:**
- Child Health Assessment** {CYSS Form or school physical can be used}
- Sports Physical** (required for all sports-related activities at time of sports sign up)
- USDA Income Eligibility Form**
- DOD Child Care Fee Application**

**All programs require an orientation prior to using services**

You can visit our Website @

**[www.knoxmwr.com](http://www.knoxmwr.com)** or call 502-624-6703

## CHILD YOUTH AND SCHOOL SERVICES REGISTRATION CARD

### DATA REQUIRED BY THE PRIVACY ACT OF 1974

**AUTHORITY:** Title 10, USC, Section 3013; Title 28 USC, Section 8041; DODD 1015.2; DODI 1015.10; AR 215-1; AR 215-3; AR 215-4; and AR 608-10.  
**PURPOSE(S):** To provide child and Family program eligibility and background information, sponsor consent for access to emergency medical care, and data required by USDA Food Program.  
**ROUTINE:** Information is furnished to the attending physician when it is necessary for a child to be taken to a medical facility by someone other than the parent. Information on immunization and medical problems will be used as part of the program admission screening procedure. Family income data will be used to determine USDA Food Program qualifications and rate structures.  
**DISCLOSURE:** Disclosure of required information is voluntary; however, if information is not provided, individuals may not be allowed to participate in CYSS programs.

**DECLARATION OF NONDISCRIMINATION.** Services will be made available to all children in attendance, without regard to race, color, religion, national origin, or sex, within the limits of AR 608-10. CYSS programs participating in the USDA Food Program shall offer meals without physical segregation of, or discrimination against, any child, regardless of ability to pay.

<b>NAME OF SPONSOR:</b>	<b>RANK:</b>		<b>SERVICE:</b> <input type="checkbox"/> ACT <input type="checkbox"/> RET <input type="checkbox"/> CIV	<b>SOLE PARENT:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>HOME ADDRESS/SPONSOR:</b>	<input type="checkbox"/> ON POST	<b>HOME PHONE:</b>	<b>DUTY ADDRESS:</b>	
	<input type="checkbox"/> OFF POST	<b>WORK/DUTY PHONE:</b>		
<b>NAME OF SPOUSE:</b>	<b>RANK:</b>		<b>SERVICE:</b> <input type="checkbox"/> ACT <input type="checkbox"/> RET <input type="checkbox"/> CIV	<b>DUAL MILITARY SPONSOR:</b> <input type="checkbox"/>
<b>HOME ADDRESS/SPOUSE:</b>	<input type="checkbox"/> ON POST	<b>HOME PHONE:</b>	<b>WORK/DUTY ADDRESS:</b>	
	<input type="checkbox"/> OFF POST	<b>WORK/DUTY PHONE:</b>		
<b>FAMILY SIZE:</b>				
<b>CHILD/TEEN'S NAME:</b>	<b>SCHOOL/PROGRAM</b>	<b>BIRTH DATE:</b>	<b>GENDER:</b>	
1.				
2.				
3.				
4.				
5.				
6.				

## MEDICAL INFORMATION

MEDICAL PROBLEMS (IF KNOWN): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## SPONSOR CONSENT

I \_\_\_\_\_ (Parent, Guardian) of \_\_\_\_\_  
 \_\_\_\_\_ give consent for an authorized CYSS staff member to take my  
 child/children for care, medical or dental, in an emergency situation where my child/children(s) condition  
 represents a serious or imminent threat to his/her life, health, or well being. I understand that a conscientious  
 effort will be made to notify me prior to such action and the expense, if any, will be borne to me. Treatment at  
 an Army medical facility may be provided without additional consent under the provision of AR 40-3,  
 paragraph 2-19.

1. USE OF PHOTOGRAPHS FOR RELEASE TO MEDIA.  YES  NO
2. PARTICIPATION IN ON- AND OFF-POST EXCURSIONS ACCOMPANIED BY CYS PERSONNEL  YES  NO
3. TRANSPORTATION IN A GOVERNMENT OR COMMERCIAL VEHICLE.  YES  NO
4. INDEPENDENT PARTICIPATION IN ATHLETIC EVENTS, CLASSES, YOUTH ORGANIZATIONS AND CLUBS, WALKING TO AND FROM SCHOOL, OR OTHER ACTIVITIES.
5. DO YOU HAVE ANY SPECIAL INSTRUCTIONS FOR YOUR 11-12 YEAR OLDS ARRIVAL OR DEPARTURE FROM THE YOUTH CENTER? YES \_\_\_\_\_ NO \_\_\_\_\_

EMERGENCY CHILD RELEASE DESIGNEE:	CELL PHONE:	HOME PHONE:	WORK PHONE:
EMERGENCY CHILD RELEASE DESIGNEE:	CELL PHONE:	HOME PHONE:	WORK PHONE:
SIGNATURE OF SPONSOR:		DATE:	

**CHILD DEVELOPMENT SERVICE (CDS) SPONSOR/PROGRAM AGREEMENT**

For use of this form, see AR 608-10; the proponent agency is ODCSPER

**DATA REQUIRED BY THE PRIVACY ACT OF 1974**

**AUTHORITY:** Title 10, United States Code, Section 3013

**PRINCIPAL PURPOSE:** Information is used by DA personnel and patrons to: (1) Identify and clarify responsibilities of all parties involved in agreement, (2) specify commitment regarding acceptance and provision of CDS services.

**ROUTINE USES:** Information provided may be released IAW the Army's blanket routine uses contained in AR 340-21.

**DISCLOSURE:** Disclosure of requested information is voluntary; however, if information is not provided, individuals may not be able to participate in CDS programs.

**NAME OF SPONSOR** (Last, First, MI)

**PROGRAM** \_\_\_\_\_ **VALID FROM** (Month, day, year to month, day, year) \_\_\_\_\_

**SERVICE** (Check appropriate box)

FULL DAY     PART DAY PRESCHOOL     PART DAY SCHOOL AGE     FCC HOME     HOURLY

**AGE GROUP CATEGORY** (Check appropriate box)

INFANT     TODDLER     PRESCHOOL AGE     SCHOOL AGE

I agree to enroll my child/children \_\_\_\_\_

In the \_\_\_\_\_

CDS Facility/Family Child Care Home located at \_\_\_\_\_

**PROGRAM SERVICES**

**PROGRAM OPERATING HOURS ARE AS FOLLOWS** (List hours) (CDS personnel)

MON 530 TO 1800    TUES 530 TO 1800    WED 530 TO 1800  
THURS 530 TO 1800    FRI 530 TO 1800    SAT \_\_\_\_\_ TO \_\_\_\_\_  
SUN \_\_\_\_\_ TO \_\_\_\_\_

**\*SERVICES FOR MY CHILD/CHILDREN WILL BE AS FOLLOWS** (List hours) (Sponsor)

MON \_\_\_\_\_ TO \_\_\_\_\_    TUES \_\_\_\_\_ TO \_\_\_\_\_    WED \_\_\_\_\_ TO \_\_\_\_\_  
THURS \_\_\_\_\_ TO \_\_\_\_\_    FRI \_\_\_\_\_ TO \_\_\_\_\_    SAT \_\_\_\_\_ TO \_\_\_\_\_  
SUN \_\_\_\_\_ TO \_\_\_\_\_

**SERVICES WILL NOT BE AVAILABLE ON** (List time/date) (CDS personnel)

Federal Holidays with no reduction in fees \_\_\_\_\_ I WILL BE NOTIFIED IN ADVANCE, WHENEVER POSSIBLE,  
OF ADDITIONAL PERIODS OF NON-SERVICE AS DETERMINED BY CDS PERSONNEL  
(CHILD MAY BE DENIED CARE WHEN ILLNESS PRECLUDES PARTICIPATION IN ROUTINE PROGRAM ACTIVITIES )

**PRIOR NOTICE REQUIREMENT** (List amount of time required to terminate services) (CDS Personnel)

A 14 day written notice to withdraw from a program. (Fees accrue until notice is given.) A 7 day written notice to take leave. Hourly care patrons will be charged for a minimum reservation of 2 hours if not cancelled within 24 hours.

**UNIQUE CONSIDERATIONS** (Sponsor)

I REQUEST THE FOLLOWING SPECIAL NEEDS OF MY CHILD/CHILDREN AS ACCOMMODATED \_\_\_\_\_

MY CHILD/CHILDREN REQUIRES THE FOLLOWING SPECIAL ITEMS WHICH I WILL SUPPLY \_\_\_\_\_

\*NON APPLICABLE FOR HOURLY SERVICES

**FEES AND CHARGES (CDS Personnel)**

RATES FOR PROGRAM SERVICES ARE AS FOLLOWS:

Total Family Income (TFI) \$ \_\_\_\_\_ CAT 1 2 3 4 5 6 Child #1 \_\_\_\_\_ Child #2 \_\_\_\_\_ Hourly Rates:  
CDC \$3.50 hr/child, Cat I \$2.50 hr/child, SAS \$2.50 hr/child, Cat I \$2.00hr/child.

MISCELLANEOUS FEES FOR PROGRAM SERVICES ARE AS FOLLOWS:

Some isolated field trip fees.

AN OVERTIME/LATE FEE OF \$ 1.00 per minute WILL BE CHARGED STARTING AT 1806 HOURS.

\*PAYMENT OBLIGATION IS BASED ON HOURS I AGREE TO USE SERVICES NOT ON ACTUAL HOURS OF CHILD ATTENDANCE, UNLESS THEY EXCEED THE HOURS CONTRACTED.

\*IN THE EVENT OF ABSENCE OF MY CHILD/CHILDREN FROM CARE DUE TO ILLNESS, FEES WILL/WILL NOT BE REDUCED.

\*IN THE EVENT OF ABSENCE OF MY CHILD/CHILDREN FROM CARE DUE TO VACATION, FEES WILL/WILL NOT BE REDUCED.

FEES WILL BE PAID IN THE FOLLOWING MANNER

Payments are due in advance on the 1st and 15th of each month. If dates fall on a weekend or Federal Holiday, payment is due the next business day. CDC&SAS prog. will apply late fees of \$5.00. Patrons whose accounts are not paid in full by the 8th working day after due date will be denied care. Late pick up fee not to exceed \$15.00/fam/site.

FEES AND CHARGES ARE SUBJECT TO CHANGE. PATRONS WILL BE NOTIFIED OF CHANGES 30 DAYS PRIOR TO EFFECTIVE DATE.

**POLICIES (CDS Personnel)**

\*CHILD MEDICATION WILL BE ADMINISTERED ONLY UPON MY WRITTEN REQUEST UNDER THE FOLLOWING CDS CONDITIONS

Medication will be given if the child has been on prescribed medication for 24 hrs. Parents must fill out medication card (DA5225-R). Over the counter or "as needed" medications will not be given. No medication will be administered in hourly care program.

LAUNDERING CHILD'S/CHILDREN'S SOILED CLOTHING WILL/WILL NOT BE DONE ON A ROUTINE BASIS.

I WILL PROVIDE THE FOLLOWING TO MEET CDS PROGRAM REQUIREMENTS

Attend mandatory orientation prior to using CYS services. Provide Emergency Designee prior to using services. Ensure immunizations are updated as scheduled. Provide updated information on family status. \*Single/Dual Military provide a Family Care Plan within 30 days of registration.

I ACKNOWLEDGE A SHARED RESPONSIBILITY WITH CDS FOR CHILD ABUSE PREVENTION

All suspected cases of child abuse and neglect will be reported to the proper authorities. No child will be released to anyone other than parent or emergency designee without prior arrangements made with the Program Director in writing.

I ACKNOWLEDGE AND CONSENT TO THE FOLLOWING CDS POLICIES CONCERNING THE CARE OF MY CHILD

If a child becomes ill or injured, the parent or Emergency Designee will be called. Child must be picked up within 30 minutes. Children wearing a cast, sling or having stitches must have a written statement signed by physician approving child's admission to attend program activities. All items of clothing should be labeled. The CDC is not liable for any loss or damaged clothing. Children should wear clothing that is comfortable and easily washed. Tennis shoes are recommended type of footwear. Sandals, jellies and cowboy boots should not be worn at anytime.

SIGNATURE OF SPONSOR

DATE

SIGNATURE OF CDS REPRESENTATIVE OR FCC PROVIDER

DATE

## ARMY CHILD AND YOUTH SERVICES HEALTH SCREENING TOOL

For use of this form, see AR 608-75; the proponent agency is OACSIM.

### PRIVACY ACT STATEMENT

**AUTHORITY:** 10 U.S.C. 3013, Secretary of the Army; 29 U.S.C. 794, Nondiscrimination Under Federal Grants and Programs; DoDD 1342.17 Family Policy; AR 608-75, Exceptional Family Member Program; AR 608-10, Child Development Services; and E.O. 9397 (SSN).

**PRINCIPAL PURPOSE:** Information will be used to assist Army activities in their responsibilities in overall execution of the Army's Exceptional Family Member Program (EFMP) and the Army Child and Youth Services Program.

**ROUTINE USES:** The DoD "Blanket Routine Uses" that appear at the beginning of the Army's compilation of systems of records apply to this system.

**DISCLOSURE:** Disclosure of requested information is voluntary; however, if information is not provided individual may not be able to participate in Army Child and Youth Services Program.

### Part A - General Information

1. Child's Name		2. Date of birth (YYYYMMDD)
3. Family member prefix		
4. Type of placement requested		5. Date (YYYYMMDD)
6. Sponsor name		7. SSN (last four digits)
8. Spouse name		
9. Home phone	10. Duty phone	11. Cell phone

### Part B - Identification of Child/Youth Condition/Restrictions

Child has any of the following conditions/restrictions: (Check yes or no)

1. Allergies	
<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
a. Life threatening reaction	
<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
b. Epi-pen required	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
c. Other allergic reactions (hives, rash, diarrhea)	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
2. Asthma reactive airway disease	
<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
a. Triggers exist for child's asthma attacks (stress, environmental, exercise)	
<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
b. Child routinely (greater than 10 days per month/four months per year) uses inhaled anti-inflammatory agents and/or bronchodilators	
<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
c. Child has taken steroids during the past year (prednisone, prednisolone)	
<input type="checkbox"/> No	<input type="checkbox"/> Yes (indicate number of days in past year)

d. Child has experienced unconsciousness or seizures associated with asthma attacks	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
e. Child required an urgent visit to emergency room or clinic for acute asthma within the last 12 months	<input type="checkbox"/> No	<input type="checkbox"/> Yes (indicate number of visits in the past year)
f. Child has been hospitalized for asthma related condition in the past six months	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
3. Attention Deficit Disorder (ADD)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
a. ADD with hyperactivity	<input type="checkbox"/> No	<input type="checkbox"/> Yes
b. Is not well controlled with medication	<input type="checkbox"/> No	<input type="checkbox"/> Yes (not well controlled)
c. Behavioral/conduct concerns	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
4. Autism	<input type="checkbox"/> No	<input type="checkbox"/> Yes
5. Behavioral/conduct concerns (for example, oppositional defiant disorder, anxiety disorder, school phobias)	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
6. Blindness/visual problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
7. Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
8. Emotional problems that require care by a psychiatrist, psychologist or social worker	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
9. Epilepsy	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
10. Hearing problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
11. Heart problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
12. Kidney problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
13. Speech/language delay	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
14. Physical disability	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
15. Dietary restrictions	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)

16. Assistance with activities of daily living  
 No  Yes (explain)

17. Other conditions  
 No  Yes (specify and explain)

**Part C - Medications**

Child is on medications on a regular basis  
 No  Yes (If yes, please list medications and indicate which require administration during child care hours.)

**Part D - Early Intervention and Special Education**

Child has an Individualized Family Service Plan (IFSP), Individualized Education Plan (IEP) or 504 plan  
 No  Yes

**Part E - Exceptional Family Member Program (EFMP) Enrollment**

Child is enrolled in the EFMP  
 No  Yes (specify for what condition)

I authorize \_\_\_\_\_ (name of Medical Treatment Facility or physician's practice) to release any medical information regarding my child \_\_\_\_\_ (name of child) to the \_\_\_\_\_ (name of installation) Child Youth Services (CYS)/Special Needs Accommodation Process (SNAP) personnel and their staff that is necessary to conduct SNAP review. This authorization will remain in effect for one year. I understand I may revoke this consent in writing at any time before expiration, but any action taken by the CYS/SNAP in reliance on this authorization prior to revocation is valid and will remain in effect.

I understand that information disclosed pursuant to this authorization is For Official Use Only (FOUO) and may be subject to redisclosure. I understand that information redisclosed is no longer protected by DoD 6025.18-R; however, confidentiality of this information will remain protected by the Privacy Act of 1974, 5 U.S.C. section 552a.

The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.

\_\_\_\_\_  
Signature of Parent or Personal Representative of Child

\_\_\_\_\_  
Date (YYYYMMDD)

## CHILD AND YOUTH SERVICES HEALTH ASSESSMENT / SPORTS PHYSICAL

DATA REQUIRED BY THE PRIVACY ACT OF 1994			
<p><b>PRINCIPAL PURPOSE:</b> Information is used by DA personnel to: (1) verify child health status of immunization per admission requirements; (2) note special program considerations or restriction on child participation; (3) execute emergency medical procedure for chronic illnesses/conditions; (4) refer child for enrollment in Exceptional Family Member Program; (5) certify physically fit to participate in sports. <b>ROUTINE USES:</b> No information is disclosed outside DOD. <b>DISCLOSURE:</b> Information is voluntary; however, if information is not provided, individuals may not be able to participate in community activities.</p>			
<p><b>INSTRUCTIONS:</b> Health Assessment complete sections A &amp; C; Sports Physicals complete sections A, B &amp; C.</p>			
<b>PART A</b>			
Name of Sponsor		Home Telephone	Duty/Work Telephone
		Cell Telephone	
Sponsor Unit / Work Address		Sponsor SSN	Spouse's Work Telephone
<b>CHILD HEALTH INFORMATION</b>			
Name of Child		Birth Date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
<p>Does your child have ongoing medical concerns? (If Yes, explain circumstances and current status)</p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>			
<p>Is your child enrolled in Exceptional Family Member Program? (If Yes, explain)</p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>			
<b>MEDICAL HISTORY</b>			
	YES	NO	YES    NO
1. Any hospitalization or operations			14. Heat stroke or exhaustion
2. Allergies to medicine, insect bites or food			15. Broken bones or sprains
3. Speech or development delays			16. Joint Injuries (Ankle/Knee/Wrist)
4. Vision Problems (Glasses / Contacts)			17. Required restricted physical activity
5. Ear or hearing problems			18. Diabetes
6. Seizures or Convulsions			19. Cancer
7. Dizziness or fainting with exercise			20. Dental or orthodontic braces
8. Headaches			21. Learning problems
9. Head injury or loss of consciousness			22. Sleep problems
10. Neck or back injury			23. Behavioral problems
11. Asthma or difficulty breathing			24. ADD / ADHD
12. Heart or blood pressure problems			25. Other problems (list below)
13. Chest pain with exercise			
If you answer yes to any of the above, please explain:			
<b>Ongoing Medications</b>			
Name		Dosage	Frequency
<b>Allergies - All Types (Foods, Medicines and Insect Bites)</b>			
Type		Reaction	

PART B: SPORTS PHYSICAL				
Medical Staff Assessment (Completed by licensed independent practitioner)				
Age YRS	MOS	Height cm.	Weight kgs.	
BP: /		Visual Acuity	Tested with / without glasses	
P:		Right /	Left /	
	NORMAL	ABNORMAL	N / A	COMMENTS
1. Eyes				
2. Ears, Nose & Throat				
3. Hearing				
4. Mouth & Teeth				
5. Neck (Soft tissues)				
6. Cardiovascular				
7. Chest & Lungs				
8. Abdomen				
9. Genitalia - Hernia				
10. Skin & Lymphatics				
11. Spine - Scoliosis				
12. Extremities				
13. Neurological				
14. Wears braces / plates				

Based on this HX and PX exam, the following abnormalities were found and may need treatment:

Immunizations are current and up to date:  Yes  No

**PARTICIPATION RECOMMENDATIONS**

All sports \_\_\_\_ Yes \_\_\_\_ No  Normal physical activity to including PE

PA Additional comments:  Restrictions:

Sports Physical is valid for 1 year from date indicated below

PART C		
Special Medical Considerations: Describe any special program needs, considerations or restrictions which the child requires in order to participate in CYS programs (to include Sports).		
Child / Youth is able to participate in normal CYS programs? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date	Licensed Health Care Professional Stamp	Licensed Health Care Professional Signature
Date	Type or print name of Parent or Guardian	Signature of Parent or Guardian

Health Assessment Re-Certification		
Date	Health Status Changed	Signature of Parent or Guardian
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Date	Health Status Changed	Signature of Parent or Guardian
	<input type="checkbox"/> Yes <input type="checkbox"/> No	



**DEPARTMENT OF THE ARMY  
US ARMY INSTALLATION MANAGEMENT COMMAND  
HEADQUARTERS, US ARMY GARRISON COMMAND, FORT KNOX  
1681 BULLION BOULEVARD  
FORT KNOX, KENTUCKY 40121-2266  
August 11, 2008**

REPLY TO  
ATTENTION OF:

Child and Youth Services

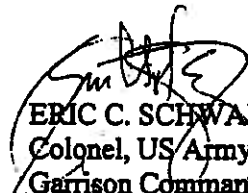
Dear Parents/Guardian:

There are two income related forms included in the Child and Youth Services (CYS) registration packet. In order to register with CYS, the completion of these forms is mandatory.

The Kentucky Child and Adult Care Food Program Income application is required on each child/youth enrolled in CYS. This completed and signed application form determines families for free, reduced, or paid meals. Also, the Department of Defense Child Care Fee – DD Form 2652 is required in order to calculate total family income. The purpose of these forms is to determine how much money the State reimburses the food programs within the Child Development Center, School Age Services, and Youth Services.

Thank you for helping us provide a first class program for the children and youth at Fort Knox. If you have questions or need more information, please contact Ms. Sharon Orr, Food Nutritionist, at 624-6706.

Sincerely,

  
ERIC C. SCHWARTZ  
Colonel, US Army  
Garrison Commander

Enclosure

# PLEASE ANSWER EACH QUESTION

## APPLICATION FOR DEPARTMENT OF DEFENSE CHILD CARE FEES

### PRIVACY ACT STATEMENT

**AUTHORITY:** Public Law 101-189, Section 1504; E.O. 9387.

**PRINCIPAL PURPOSE(S):** To collect total family income data to determine child care fees.

**ROUTINE USE(S):** None.

**DISCLOSURE:** Voluntary; however, failure to furnish information will result in placement in the highest fee range.

### SECTION I - DEPENDENT CHILDREN

To determine child care fees for your child(ren), or any child(ren) you legally claim as your dependent(s), you must complete, sign, and return this form to the director of the program you are applying for. Fees will be determined based on your total family income as defined below. If you do not wish to disclose your total family income, your rate will be set automatically at the highest fee level.

1. NAME OF EACH CHILD (LAST, First, Middle Initial)	2. DATE OF BIRTH (YYYYMMDD)	3. AGE	4. CARE REQUESTED
a.			
b.			
c.			
d.			
e.			

### SECTION II - ANNUAL FAMILY INCOME (To be completed by sponsor. Include all military and civilian earned income for sponsor and spouse.)

Enter your annual income data as requested; e.g., multiply the most recent monthly income by 12 or if paid on a biweekly income, enter the most recent biweekly income and multiply by 26. For purpose of determining child care fees in DoD Child Care program, total family income is defined as all earned income including wages, salaries, tips, long-term disability benefits, combat pay and voluntary salary deferrals. Include all earned income such as wages, salaries, tips, long-term disability benefits, voluntary salary deferrals, retirement or other pension income, etc., before deductions for taxes, social security, etc. Include quarters subsistence and other allowances appropriate for the rank and status of military or civilian personnel whether received in cash or in kind. For dual military living in government quarters include BAH-II of senior member only. Include anything else of value, even if not taxable, that was received for providing services. DO NOT INCLUDE cost of living allowance (COLA) received in high cost areas, alimony and child support, temporary duty allowances or reimbursements for educational expenses.

#### 5. SPONSOR

a. NAME (LAST, First, Middle Initial)	b. SSN	c. YEARS OF MILITARY/CIVIL SERVICE
(1) INCOME (1) <b>BASE PAY</b> (Most recent leave and earnings statement)                    (2) <b>BASIC ALLOWANCE FOR HOUSING</b> (Or in-kind equivalent) (Annual chart of minimum BAH-II)                    (3) <b>BASIC SUBSISTENCE ALLOWANCE</b> (Or in-kind equivalent)                    (4) <b>OTHER EARNED INCOME AS DESCRIBED ABOVE</b>		

#### 6. SPOUSE

a. NAME (LAST, First, Middle Initial)	b. SSN	c. YEARS OF MILITARY/CIVIL SERVICE
d. INCOME		

#### 7. OTHER EARNED INCOME AS DESCRIBED ABOVE

8. TOTAL INCOME FOR SPONSOR, SPOUSE, AND OTHER

### SECTION III - CERTIFICATION OF SPONSOR (Required for Category I - IV. Please read the following statement carefully before signing.)

I certify that all of the above information is true and correct and that all family income of the spouse and sponsor is reported. I understand that this information is being given in order to determine child care fees to be paid and that Federal funds are used to subsidize the cost of child care. I also understand that the installation commander may verify the information on the application; and that deliberate misrepresentation of this information may subject me to prosecution under applicable State and Federal laws. See 18 U.S.C. Section 1001.

9. SIGNATURE OF SPONSOR*	10. SIGNATURE OF SPOUSE	11. DATE SIGNED (YYYYMMDD)
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\*If signature is missing, the fees will automatically be placed at the highest level.

12. TELEPHONE NUMBERS (Include Area Code)		13. HOME ADDRESS (List apartment number and 9-digit ZIP Code)
a. HOME	b. WORK	
(1) SPONSOR		
(2) SPOUSE		

### SECTION IV - FOR CHILD DEVELOPMENT CENTER USE ONLY

14. CATEGORY OF APPROVAL	15. AUTHORIZED FEES
16. DATE OF APPROVAL (YYYYMMDD)	17. NAME OF CHILD DEVELOPMENT PROGRAM OFFICIAL

SECTION 5d (1) (2) (3) (4) FOR AGENCY COMPLETION ONLY



**2009-2010 Child Care Sponsors**

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

**INCOME ELIGIBILITY GUIDELINES**  
**Effective July 1, 2009 – June 30, 2010**

<u>Household Size</u>	<u>Annual</u>	<u>Monthly</u>	<u>Weekly</u>
1	\$20,036	\$1,670	\$ 386
2	\$26,955	\$2,247	\$ 519
3	\$33,874	\$2,823	\$ 652
4	\$40,793	\$3,400	\$ 785
5	\$47,712	\$3,976	\$ 918
6	\$54,631	\$4,553	\$ 1,051
7	\$61,550	\$5,130	\$ 1,184
8	\$68,469	\$5,706	\$ 1,317
For each additional member, add	\$ 6,919	\$ 577	\$ 134

**Non-discrimination Statement:** 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 to USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

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 Sponsor Representative

\_\_\_\_\_  
 Phone Number

If you have questions about the CACFP and its administration, you may contact Paul McElwain, Division Director or Denise Hagan, Community Nutrition Branch Manager, at 502/564-5625 or at the following address: Nutrition and Health Services, Kentucky Department of Education, 2545 Lawrenceburg Road, Frankfort, KY 40601.