U.S. Army Child, Youth & School Services

ARMY CHILD, YOUTH & SCHOOL (CYS) SERVICES
Parent Central Services Office Registration Checklist

Children/youth must be fully registered before they can use nay CYS Services programs.
Contact your local Parent Central Services Office to set up an appointment to complete your registration.
Limited "walk-in' services may also be available.

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

ITEMS / INFORMATION TO BRING TO YOUR REGISTRATION APPOINTMENT: **Verification**

- □ **Sponsor's Social Security Number** [Needed for Child Care Tax Credit, USDA funding, medical service identifier. Patron privacy is protected.] _____
- □ **Proof of Child Eligibility** (i.e. Legal Guardianship papers or Child Military ID Card) _____
- □ **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 and any private accounts you regularly check) _____
- □ **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) _____
- □ **Local Emergency and Child Release Designees** (minimum of 2) (Need names/phone numbers we can contact or release your child to in an emergency situation if we are unable to reach you _____
- □ **Family Care Plan Short-Term Release Designee** (Required for single/dual military and single/dual deployable civilian families) (Need name, address, phone numbers of designee) [Due within 30 days] _____
- □ **Child's Official Shot Record** _____
- □ **Deployment Orders** (Families of deployed individuals can obtain Army Family Covenant discounts and benefits with proof of deployment) _____

FORMS COMPLETED BEFORE / DURING / AFTER YOUR VISIT: **Verification**
[Downloadable blank/fillable forms are available on line – click 'Forms/Links' in the menu bar]

- □ **Child Health Assessment** (CYSS Health Form Parts A, B & C {or Part A + School Physical}) [Due within 30 days] _____
- □ **Sports Physical** (CYSS Health Form Parts A,B & C) [Due before participation in all sports activities] _____
- □ **USDA Income Eligibility Form** (Allows us to receive additional funding to support meals/snacks provided) _____
- □ **DOD Child Care Fee Application** (To evaluate household income for eligibility for reduced fees) _____
- □ **Health Screening Tool** (To record/evaluate child's allergies, medical/physical conditions, etc.) _____
- □ **Medical Action Plan (MAP)** (Only needed if a child is diagnosed with allergies, diabetes, asthma/respiratory, or seizures that require staff to give rescue medication). [If recommended by Special Needs Assessment Team] _____

ASK ABOUT SPECIFIC CYS SERVICES PROGRAMS AVAILABLE AT YOUR GARRISON – POSSIBILITIES INCLUDE:

- Full/Part Day Child Care
- Part Day Preschool
- Hourly Care
- Before/After School Care
- Kids on Site
- Vacation Camps
- EDGE! Partnership Activities
- imAlone
- Home School Support
- Strong Beginnings
- Middle School/Teen Activities
- Youth Sports
- SKIESUnlimited Classes
- HIRED! Youth Apprenticeships
- And More . . . . .

Army Child, Youth and School (CYS) Services
Program Registration & Consent Form

DATA REQUIRED BY THE PRIVACY ACT OF 1974
AUTHORITY: Title 10, United States Code, Section 3012. **PRINCIPAL PURPOSE(S)**: To provide child and family program eligibility, background information and sponsor consent for access to emergency medical care. **ROUTINE USES**: Information is furnished to the attending physician when it is necessary for an individual to be taken to a medical facility by someone other than the parent. **DISCLOSURE**: Disclosure of requested information is voluntary, however, if information is not provided, individual(s) may not be allowed to participate in the CYS Program. **DECLARATION OF NONDISCRIMINATION**: Services will be made available to all youth in attendance, without regard to race, religion, national origin, ancestry, or sex, within the limits of AR 608-10.

Sponsor's Name: ____ Grade/ Rank: ______________
Last First MI
Status: Active Duty Guard Reserve DoD Civilian Eligible Contractor Other
Branch of Service: Army Air Force Navy Marine Corps Coast Guard
Installation Assigned to: ____
Unit/Employer: ____ Duty Phone: ______________________
Unit/Employer Address: ____
Home Address: ____ City: _________________________
Home Phone: __________________ Cell Phone: ___________________ Live On-Post? Yes No
Sponsor's Email Address (AKO Preferred): ______________________________________
I want to receive email information and announcements about CYS Programs and Events: Yes No

Spouse's Name: ____ Grade/Rank: _____________
Last First MI
Status: Active Duty Guard Reserve DoD Civilian Eligible Contractor
Student Retired Military Other (Please Specify) ______________________
Branch of Service: Army Air Force Navy Marine Corps Coast Guard
Unit/Employer: ____ Duty Phone: _____________________
Unit/Employer Address: ____
Home Phone: ________________________ Cell Phone: ________________________
Spouse's Email Address (AKO Preferred): ______________________________________

Child's Name: ____ Nickname: ________________________
Last First MI
Gender: Male Female Date of Birth: ___/___ /_____ Age: _____ Grade: _______
MM DD YYYY

Child's Name: ____ Nickname: ________________________
Last First MI
Gender: Male Female Date of Birth: ___/___ /_____ Age: _____ Grade: _______
MM DD YYYY

Child's Name: ____ Nickname: ________________________
Last First MI
Gender: Male Female Date of Birth: ___/___ /_____ Age: _____ Grade: _______
MM DD YYYY

Child's Name: ____ Nickname: ________________________
Last First MI
Gender: Male Female Date of Birth: ___/___ /_____ Age: _____ Grade: _______
MM DD YYYY

Child's Name: ____ Nickname: ________________________
Last First MI
Gender: Male Female Date of Birth: ___/___ /_____ Age: _____ Grade: _______
MM DD YYYY

Emergency Contacts (3 Local Adults, other than sponsor or spouse, authorized to respond in an emergency)

Name: _____Home Phone: _____Cell Phone: _____
Last First MI

Relationship: _____ *Is this person authorized to pick up child? Yes No

Name: _____Home Phone: _____Cell Phone: _____
Last First MI

Relationship: _____ *Is this person authorized to pick up child? Yes No

Name: _____Home Phone: _____Cell Phone: _____
Last First MI

Relationship: _____ *Is this person authorized to pick up child? Yes No

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SPONSOR CONSENT

I, _____, Parent/Guardian of _____,
(circle one) **give consent** / **do not give consent** for an authorized CYS representative to obtain medical and/or dental care for my child in an emergency situation where his/her 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 paid by me. Treatment at an Army Medical Facility may be provided without additional consent under the provision of AR 40-3. Sponsor's Initials: _____

Does your child have permission to travel in a government/commercial vehicle to participate in CYSS Programs and events? Yes No

Can your child be photographed while participating in a CYS Program for release to media? Yes No

SPONSOR'S SIGNATURE: _____ DATE: _____

Verifying Staff Member: _____ Verification Date: _____
Special Needs? Yes No (If Yes) Date Received DA Form 7625-1 from Sponsor _____

***Sole/Dual Military Family: As prescribed by AR 600-20 and AR 608-10, military personnel are required to maintain an accurate Family Care Plan. DA Form 5305-R must be completed within 30 days of CYSS registration or services may be denied. The Family Care Plan must be updated annually. Sponsor's Initials: _____

The following additional documentation is **REQUIRED** no later than 30 days from initial registration; failure to provide this information will result in denial of CYSS Program participation.

_____ Family Care Plan Suspense Due Date_____

_____ Health Assessment Suspense Due Date_____

_____ Emergency Contacts Suspense Due Date_____

ARMY CHILD AND YOUTH SERVICES HEALTH SCREENING – TOOL #1

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.

SNAP Case Number: _____

FOR CER COMPLETION ONLY

□ Initial Registration
Is child on waiting list? □ Yes □ No
Date care needed? _____
□ Re-registration/Child Already in Program
□ Change in Program

Date in from Patron:

Date out to APHN:

Part A – General Information

Child/Youth Name	Child/Youth School Grade (example: 3rd Grade)	Date of birth (YYYYMMDD)	Age

Type of Placement Requested: (check all that apply)
□ Hourly Care □ Full Day Care □ Middle School/Teen Program □ Summer Camp □ Other: (specify)
□ Part Day Care □ Before/After School Care □ SKIES/Instructional Classes □ Sports

Sponsor Name	Sponsor E-mail	Sponsor SSN

Spouse Name	Spouse E-mail

Home Phone	Cell Phone	Sponsor Unit

Home Address	Sponsor Duty Phone

Part B – Identification of Child/Youth Condition/Restrictions

Does you child have any of the following conditions/restrictions: (check no or yes and answer questions as appropriate)

1. Allergies
   a. Life threatening reaction? □ No □ Yes
   b. Rescue Medication (Epi-pen, Benadryl, Inhaler) □ No □ Yes
   c. Does child/youth need rescue inhaler? □ No □ Yes
   If your child/youth has an allergy, please list: _____
   _____
   Reaction: _____
   _____
2. Special Diet □ No □ Yes
   a. Is your child on a complex diet (i.e. gluten free, diabetic) □ No □ Yes
   b. Does your child have a food intolerance/mild food allergy (i.e. rash from strawberries/milk intolerance)? □ No □ Yes
   c. Does your child have a dietary religious restriction? □ No □ Yes
3. Asthma/Reactive Airway Disease/Breathing Problems? □ No □ Yes
   a. Does your child need a rescue med? □ No □ Yes
4. Does your child have diabetes? □ No □ Yes
5. Does your child have seizures? □ No □ Yes
6. Attention Deficit Disorder (ADD/ADHD)
   a. Are there behavior/conduct concerns while on meds? □ No □ Yes
   b. List ADD/ADHD medications: _____
   _____
   _____
   _____
7. Behavior/ conduct concerns (oppositional defiant disorder, anxiety, depression, bipolar, other)? □ No □ Yes
8. Autism Spectrum Disorders (Autism, Aspergers, Rett Syndrome, PDD-NOS) □ No □ Yes
9. Does your child have any of the following health concerns? (circle all that apply)- Hearing impairment, vision impairment other than corrective lenses, heart, kidney, physical disability SEVERE skin condition □ No □ Yes
   Please specify _____
   _____
10. Does your child have a speech/language and/or hearing loss that affects their ability to communicate their basic needs (hurt, bathroom, fear, thirst)? □ No □ Yes
    Explain: _____
    _____
    _____
11. Does your child have developmental delays other than MILD speech language/MILD hearing loss? □ No □ Yes
    Explain: _____
    _____
12. Are there any other conditions or concerns that you would Like staff to be aware of? □ No □ Yes
    Explain: _____

Part C – Medications

List any medications that are prescribed for your child/youth other than those listed above:

Will your child require medication administration during child care/youth supervision hours? □ No □ Yes

Part D – Early Intervention and Special Education

Does your child/youth receive special services/therapies? □ No □ Yes
Please specify: _____

Does your child/youth have an Individualized Education Plan (IEP), Individualized Family Service Plan (IFSP) or 504 Plan? □ No □ Yes

Part E – Exceptional Family Member Program (EFMP) Enrollment

Is your child enrolled in the EFMP? □ No □ Yes If yes, specify for what condition: _____

_____ _____
Printed Name and Signature of Parent/Personal Representative of Child/Youth Date (YYYYMMDD)

If you have answered NO to all the questions above you are now finished with this form.
Please sign and date indicating that the information above is accurate and complete to the best of your knowledge.

Child, Youth and School Services strives to provide the safest and healthiest environment for your child/youth and relies on your accurate and honest information to support this goal. Please understand that placement and/or care for your child/youth could be delayed/suspended if information is falsified or intentionally omitted on registration documentation. If there are any changes to your child/youth's health please notify CYS Services immediately.

If you answered YES to any of the questions above, complete Part F on the next page.

Child/Youth Name	Date of birth (YYYYMMDD)	Age

Part F – Release of Information

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 SNAP 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.

_____ _____

Printed Name and Signature of Parent/Personal Representative of Child | Date (YYYYMMDD)

Part G – Army Public Health Nurse (APHN) Review

Current Medications other than those listed on page 1:

Diagnosis: _____

Background/Notes:

Medical Records Reviewed? □ No □ Yes □ Not Available

Training for CYS Staff/Provider Required:

Recommendation Summary:

SNAP REQUIRED: □ No SNAP required □ Modified □ Full □ Annual Review (No team meeting required)

Requirements Prior to Placement:

Medical Action Plan reviewed by APHN: □ Respiratory □ Allergy □ Seizure □ Diabetes □ Special Diet □ Other_____

APHN Printed Name or Stamp	APHN Signature	Date (YYYYMMDD)

Date Received by APHN	Date Returned to CER:

Form Updated: 11 Mar 09

CHILD AND YOUTH SERVICES HEALTH ASSESSMENT / SPORTS PHYSICAL

DATA REQUIRED BY THE PRIVACY ACT OF 1994

PRINCIPAL PURPOSE: 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. **ROUTINE USES:** No information is disclosed outside DOD. **DISCLOSURE:** Information is voluntary; however, if information is not provided, individuals may not be able to participate in community activities.

INSTRUCTIONS: Health Assessment complete sections A & C; Sports Physicals complete sections A, B & C.

PART A

Name of Sponsor	Home Telephone Cell Telephone	Duty/Work Telephone
Sponsor Unit / Work Address	Sponsor SSN	Spouse's Work Telephone

CHILD HEALTH INFORMATION

Name of Child	Birth Date	Sex ☐ Male ☐ Female

Does your child have ongoing medical concerns?
(If Yes, explain circumstances and current status)

☐ Yes ☐ No

Is your child enrolled in Exceptional Family Member Program?
(If Yes, explain)

☐ Yes ☐ No

MEDICAL HISTORY

	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:

Ongoing Medications

Name	Dosage	Frequency

Allergies – All Types (Foods, Medicines and Insect Bites)

Type	Reaction

PART B: SPORTS PHYSICAL

Medical Staff Assessment (Completed by licensed independent practitioner)

Age YRS MOS	**Height** _____ cm. (_____ %ile)	**Weight** _____ kgs. (_____ %ile)
BP: / **P:**	**Visual Acuity** Right / Left / Tested with / without glasses	

	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? ☐ Yes ☐ 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**
	☐ Yes ☐ No	
Date	**Health Status Changed**	**Signature of Parent or Guardian**
	☐ Yes ☐ No	

INCOME ELIGIBILITY STATEMENT FORM
CHILD AND ADULT CARE FOOD PROGRAM

PART I: Child or Adult enrolled to receive day care-

Name: (Last, First and Middle Initial) DOB	Food Stamp, TANF, or FDPIR case number, Assistant Unit (AU), or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. Note: Do not use EBT numbers.	Head Start Participant
		☐
		☐
		☐
		☐
		☐
		☐
		☐

PART II: FOSTER CHILD: **If this is a foster child, check here** ☐. **In certain cases, foster children are eligible for free and reduced-priced meals regardless of household income. If foster children live with you, please contact [_____] at [_____-_____-_____]. Skip to Part IV.**

Part III-A **A. Name** (List everyone in household, including children)	**B. Gross income and how often it is received** Example: $100/monthly, $100/twice a month, $100/every other week, $100/weekly				**C. Check if NO Income**
	1. Earnings from work before deductions	**2. Welfare, child support, alimony**	**3. Social Security, pensions, retirement**	**4. All other income**	
1. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
2. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
3._____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
4. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
5. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
6. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
7. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐

PART III-B: ENROLLMENT INFORMATION: Children Only

My child is normally in attendance at the facility between the hours of _____ [am/pm] to _____ [am/pm] on the following days:

☐ Check here if only before/after school care is provided.

(Circle all that apply). Sunday Monday Tuesday Wednesday Thursday Friday Saturday

My child will normally receive the following meals while in care:

(Circle all that apply): Breakfast AM Snack Lunch PM Snack Supper Evening Snack

PART IV: Signature and Social Security Number (Adult must sign).

An adult household member must sign this form. If Part III is completed the adult signing the form must also list his or her Social Security number or mark the "I don't have a Social Security Number" box. (See Privacy Act Statement on next page).

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

Signature: X_____ **Print Name** _____ **Date**_____

Address: _____ ___ **City** _____ **State: GA Zip**_____ **Phone** _____

Social Security Number _____ ☐ I do not have a Social Security Number

PART V: Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:
☐ Hispanic or Latino	☐ Asian ☐ White ☐ Black or African American ☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ Native Hawaiian or other Pacific Islander

Official Use Only: Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12

Total income: _____ Per: ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Month ☐ Year Household Size: _____

Categorical Eligibility: _____ Date withdrawn _____ Eligibility: Free _____ Reduced _____ Paid _____ Tier I _____ Tier II _____

Temporary: Free _____ Reduced _____ Time Period: _____ (expires after _____days)

Determining Official's Signature: _____ Date_____

Confirming Official's Signature: _____ Date_____

Follow Up Official's Signature: _____ Date_____

INCOME ELIGIBILITY STATEMENT FORM
CHILD AND ADULT CARE FOOD PROGRAM

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.

Household Size	Yearly Income
1	
2	
3	
4	
5	
6	
7	
8	
Each additional person	Add:

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 your child for free or reduced price meals. You must include the social security 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 Stamp, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child 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 your child is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: In accordance with Federal Law and I.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.

APPLICATION FOR DEPARTMENT OF DEFENSE CHILD CARE FEES

PRIVACY ACT STATEMENT

AUTHORITY: Public Law 101-189, Section 1504; E.O. 9397.

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. YEARS OF MILITARY/CIVIL SERVICE

c. INCOME

(1) BASE PAY *(Most recent leave and earnings statement)*	(2) BASIC ALLOWANCE FOR HOUSING *(Or in-kind equivalent) (Annual chart of minimum BAH-II)*	(3) BASIC SUBSISTENCE ALLOWANCE *(Or in-kind equivalent)*	(4) OTHER EARNED INCOME AS DESCRIBED ABOVE

6. SPOUSE

a. NAME *(LAST, First, Middle Initial)*	b. YEARS OF MILITARY/CIVIL SERVICE

c. 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 misrepresenta- tion 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)*

*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