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# NAVAL DISTRICT WASHINGTON CHILD AND YOUTH PROGRAMS TEEN CAMP ENROLLMENT



### CHILD'S INFORMATION

Name of Child: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

### SPONSOR/PARENT INFORMATION

Sponsor's Name: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

### CAMP REMINDERS

- Withdrawal from any week of camp requires two weeks written notice. If two weeks' notice is not provided to CYP, the deposit will be forfeited.
- Auto-Debit and online payment options are available.
- A registration fee equal to one week of camp fees (based on your TFI) is due at the time of registration. If withdrawals are made without two weeks written notice the registration fee is forfeited. If you are enrolled in our Auto-Debiting Program you do NOT have to pay a one week deposit at the time of registration, your camp fee will be charged on each bill date listed below. If withdrawals are made without two weeks written notice by participants of the Auto-Debiting Program you will continue to be charged based on the number of weeks you have omitted to. If registration fee is forfeited, and patron wished to re-register for camp a new registration fee equal to one week is due upon return to the program
- All Activities, movies, games and materials will be rated T-Teen or PG-13.
- Please be prepared to go outside daily (teens should bring a water bottle and sun block daily) and participate in activities that require comfortable clothes and tennis shoes.
- Teens are responsible for providing their lunch.

\*\*Note our CYP facilities are Peanut/Tree Nut Free therefore food items containing Peanuts/Tree Nuts may not be consumed while at camp.

### INITIAL BELOW EACH WEEK THE CHILD IS ATTENDING

Week 1: July 14-16 \_\_\_\_\_ Week 2: July 21-23 \_\_\_\_\_

Week 3: July 28-30 \_\_\_\_\_ Week 4: August 11-13 \_\_\_\_\_

\_\_\_\_\_  
Sponsors Signature

\_\_\_\_\_  
Date

#### FOR OFFICE USE ONLY

CYMS Enrollment Date \_\_\_\_\_ User Initials \_\_\_\_\_

Enrolled in Auto-Debiting  Yes  No User Initials \_\_\_\_\_

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# NAVY CHILD AND YOUTH PROGRAMS REGISTRATION FORM

START DATE: \_\_\_\_\_

REQUIRING DIRECTIVE OPNAVINST 1700.9

NAME OF CHILD (LAST, FIRST, MIDDLE)		SEX	BIRTHDATE (DD/MM/YY)	AGE
SPONSORS NAME (LAST, FIRST, MIDDLE)			RANK/RATE	BRANCH
			STATUS: ACT RET RES CIV CTR COMCIV	
HOME ADDRESS (Include City and Zip Code)			HOME PHONE	
E-MAIL ADDRESS			CELL PHONE	
DUTY STATION		DUTY PHONE		PCS DATE
(CIRCLE ONE) SINGLE PARENT		DUAL MILITARY		IF SPOUSE IS MILITARY (PLEASE CIRCLE)
FULL-TIME WORKING SPOUSE		STUDENT SPOUSE		STATUS: ACT RET E PART-NL OFF
TIME WORKING SPOUSE		UNEMPLOYED SPOUSE		BRANCH
				RANK/RATE
SPOUSE'S NAME (LAST, FIRST)		PLACE OF EMPLOYMENT	PHONE NUMBER	CELL PHONE

**EMERGENCY NOTIFICATION/RELEASE DESIGNEE (other than parents) (minimum of TWO (2) LOCAL REQUIRED)**

NAME	PHONE NUMBER	RELATIONSHIP

**SCHOOL NAME:** \_\_\_\_\_

**GRADE:** \_\_\_\_\_

DATE OF LAST MEDICAL EXAM: \_\_\_\_\_ STATUS  GOOD HEALTH  IF NOT, PLEASE SPECIFY:

ALLERGIES:  YES  NO IF YES, WHAT?

SPECIAL NEEDS:  YES  NO IF YES, EXPLAIN:

**SPONSOR AGREEMENT:**

**Field Trip/Transportation Permission:** I hereby grant permission for my child to participate in Navy Child and Youth Program (CYP) sponsored field trips.

- CDC trips may include: walking in the immediate CYP facility area (infants may be transported in a buggy/stroller) or on the military installation. Preschool trips may require bus transportation (CYP or chartered).
- SAC/YP trips may include: bus transportation (CYP or chartered) to and from schools and field trip locations in the metro area. CYP may also offer planned walks in the CYP facility area and on the military installation.
- I understand that Navy CYP will provide advance, written notification of each trip outside the immediate area of the facility.

**Media Release:**

I hereby grant permission for my child to be included in the use of the following formats for the purpose of education and publicity for the Navy CYP community in perpetuity without further consideration from me:

- photographs, video, and audio used in the CYP facility and media such as: Navy CYP Facebook, military installation website, CNIC CYP website, etc.

Permission is denied for Media Release \_\_\_\_\_ (Initial Here)

**Topical Non-Prescription Product Application:**

I hereby grant permission for Navy CYP employees to apply external, topical non-prescription products such as diaper cream, sunscreen, insect repellent, etc. to my child, as needed. If I choose topically applied products that are not supplied by Navy CYP, a Materials Safety Data Sheet will be required for each product.

Permission is not granted for Topical Non-Prescription Product Application \_\_\_\_\_ (Initial Here)

I agree to release and hold harmless the United States, its officers, its agents, and its instrumentalities, against any claims, demands, actions, debts, liabilities, judgments, costs, or attorney's fees arising out of, claimed on account of, or in any manner predicated upon his/her participation in any Navy MWR/CYP activity, use of facilities and/or equipment including any loss or damage to property, any injury or death of any person, in any manner, caused or contributed to by the United States, its officers, its agents, or its instrumentalities.

**I have received a copy of and understand the policies contained in the Navy CYP Parent Handbook. Additionally, I understand that I may revoke/invoke any of the above permissions in writing at any time.**

I HEREBY GIVE MY CONSENT FOR AN AUTHORIZED CHILD AND YOUTH PROGRAM (CYP) REPRESENTATIVE TO CALL AN AMBULANCE FOR MY CHILD, \_\_\_\_\_, ONLY FOR CARE (MEDICAL OR DENTAL) IN AN EMERGENCY SITUATION. I UNDERSTAND THAT A CONSCIENTIOUS EFFORT WILL BE MADE TO NOTIFY ME OR MY EMERGENCY DESIGNEES PRIOR TO SUCH ACTION. ANY EXPENSE INCURRED WILL BE BORNE BY ME AND TREATMENT MAY TAKE PLACE AT ANY MEDICAL FACILITY.

NAME OF CHILD'S MEDICAL INSURANCE COMPANY: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ NAME OF INSURED: \_\_\_\_\_

\_\_\_\_\_  
SPONSOR SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
CYP REPRESENTATIVE SIGNATURE

\_\_\_\_\_  
DATE

**PRIVACY ACT STATEMENT:**

**AUTHORITY:** P.L. 101-89, Sec. 1507, "Military Child Care Act of 1989"; Title 5 U.S.C. 301 Department Regulations; E.O. 9397; and OPNAVINST 1700.9 "Child and Youth Programs."  
**PURPOSE:** To provide Child and Youth Programs (CYP) with authorization for medical treatment in emergency situations; identify children and sponsors; record required immunizations; and record known allergies and special instructions.  
**ROUTINE USES:** Information may be furnished to military or civilian doctors or hospitals in the course of obtaining medical attention for children. The SSN is necessary so that the Child and Youth Programs can identify the individual and his/her records. Information furnished may be disclosed to any DoD component, and upon request, to other federal, state and local governmental agencies in the pursuit of their official duties relating to proper child care. Finally, the information may be disclosed to law enforcement activities for the purpose of litigation.  
**VOLUNTARY DISCLOSURE:** Furnishing the information is voluntary; however, failure to provide the requested information could result in denial of a child's admission to the CYP.

## **INSTRUCTIONS FOR CHILD AND YOUTH PROGRAMS (CYP) REGISTRATION FORM**

A separate form shall be completed for each child registered.

The parent shall complete all the information about the family and/or child.

**STATUS BLOCK:** Circle any area(s) that apply to the status of sponsoring parent (ACT - Active Duty, RET - Retired, RES - Reservist, CIV - DoD Civilian, CTR - DoD Contractor, COM CIV - Community Civilian).

After completing the form, parent(s) must sign and date in the SPONSOR AGREEMENT section. This signature and date verifies that all information is correct and validates the agreement to allow transport for medical or other emergencies.

At least annually or when the information is outdated, a new form will be completed, signed, and dated.

A CYP representative (e.g., clerk, director, provider, etc.) will sign and date in SPONSOR AGREEMENT box as witness to the parent's signature and date.

The original Navy CYP Registration Form (CNICCYP 1700/04) shall be kept in the CYP Child Registration Form File. This file shall be maintained in an easily accessible file and shall be taken outside with the day's sign-in sheet during an evacuation drill or in the event of an emergency. A copy shall be maintained in the child administration file shall be maintained at the front desk administrative area in a locked file cabinet or locked file box. **Programs using CYMS are NOT required to maintain a separate copy in the child's administration file; however, all information must be kept current in CYMS.**

### **CHILD DEVELOPMENT HOME PROGRAMS:**

CDH providers shall maintain the original CYP Registration Form for each child in the home. Forms shall be in an easily accessible location for emergency contact or evacuation.

The CDH office shall maintain an alphabetized current copy of each child's Navy CYP Registration Form for each child enrolled.

Forms shall be in an easily accessible location (for the telephone or for evacuation).

### **FOR ALL PROGRAMS:**

Registration forms, with the sign-in sheet, shall be taken outside during an evacuation drill or in the event of an emergency.

A duplicate copy of each child's Navy CYP Registration Form, with local emergency contact numbers/names must be taken on each field trip.

Medical insurance policy numbers are not required for parents who are active duty. Social security numbers are used to identify the member for medical and insurance purposes and should not be collected.



**NAVAL DISTRICT WASHINGTON  
CHILD & YOUTH PROGRAM  
HEALTH AND MEDICAL INFORMATION**



**Part A – General Information**

START DATE (YYYYMMDD)

NAME OF CHILD (LAST, FIRST, MIDDLE)	SEX	BIRTHDATE (DD/MM/YY)	AGE
SPONSORS NAME (LAST, FIRST, MIDDLE)	RANK/RATE	BRANCH	STATUS: ACT RES CIV CTR

**Part B - Identification of Child/Youth Medical/Dietary Needs**

1. Please list any Allergies: \_\_\_\_\_

a. Epi-pen or other medication required  No  Yes

b. Other allergic reactions (ex, hives, rash)  No  Yes

2. Food Intolerance (requires food substitution due to food intolerance(s) ex, lactose intolerant)  No  Yes

3. Asthma (Reactive Airway Disease)  No  Yes

4. Medical needs requiring assistance while in care  No  Yes

Please check all that apply:

Blindness/visual problems

Diabetes

Epilepsy

Hearing problems

Heart problems

Kidney problems

Physical disability

Other chronic medical needs

Briefly describe the type of assistance your child will need while in care:

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5. Child requires medication while in care  No  Yes

**\* QUESTIONS 1-5 MAY REQUIRE ADDITIONAL DOCUMENTATION- SEE INSTRUCTIONS ON REVERSE**

6. Other needs requiring assistance while in care  No  Yes

Please check all that apply:

Communication (ex, speech/language delay)

Social-emotional (ex, anxiety disorder)

Behavior (ex, oppositional defiant disorder)

Developmental (ex, autism spectrum disorder)

Learning and attention (ex, Attention-Deficit Hyperactivity Disorder)

Briefly describe the type of assistance your child will need while in care:

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

Child is receiving services through 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

I acknowledge that all the above information is true and accurate. I understand that I must report any changes to the CYP for the purposes of providing adequate care to my child. Changes to health information may require additional medical documentation and meeting with the IAT( Inclusion Action Team).

\_\_\_\_\_  
Sponsor's Signature

\_\_\_\_\_  
Date

(SEE INSTRUCTIONS ON REVERSE)

**NAVAL DISTRICT WASHINGTON  
CHILD & YOUTH PROGRAM  
HEALTH AND MEDICAL INFORMATION  
INSTRUCTIONS**

**Part A- General Information**

**Start Date:** Print the date of when the child will start care.

**Name of Child:** Print the name of the child to whom the information pertains.

**Sex:** Print the sex of the child.

**Birthdate:** Print the date of birth of the child.

**Age:** Print the age of the child.

**Sponsors Name:** Print the name of the sponsor.

**Rank/Rate:** Print the Rank/Rate of the sponsor.

**Branch:** Print the Branch of military the sponsor belongs to.

**Status:** Circle the military Status of the sponsor:

ACT= Active Duty RES= Activated Reservist CIV=DoD Civilian CTR= DoD Contractor

**Part B- Identification of Child/Youth Needs**

1. **Please list any Allergies:** List all Allergies of the child. Include food allergies, especially requiring food substitutions.

**A. Epi-pen or other medication required:** Answer "yes" or "no" if an Epi-pen or other medication, if CYP will be required to administer the medication.

**B. Other allergic reactions (ex, hives, rash):** Answer "yes" or "no" if applicable.

*If answered "yes" to either A or B an Identified Needs Intake package containing a CYP Emergency Action Plan (EAP) (or a current EAP from your child's physician may be used) AND a Medication Administration Form completed by the child's physician is required. IF child has known food allergies, a CYP Medical Statement to Request Special Meals and/or Food Substitutions Form completed by the child's physician is also required.*

2. **Food Intolerance:** Answer "yes" or "no" as applicable. Examples include: lactose intolerant, gluten intolerant.

*If answered "yes" a CYP Medical Statement to Request Special Meals and/or Food Substitutions Form completed by the child's physician is required.*

3. **Asthma (Reactive Airway Disease):** Answer "yes" or "no" if applicable.

*If answered "yes" an Identified Needs Intake package containing a CYP Emergency Action Plan (EAP) (or a current EAP from your child's physician may be used) AND a Medication Administration Form completed by the child's physician is required.*

4. **Medical needs requiring assistance while in care:** Answer "yes" or "no" and check all boxes applicable then briefly describe the type of assistance that will be needed, if applicable.

*If answered "yes", an Identified Needs Intake package containing a CYP Emergency Action Plan (EAP) (or a current EAP from your child's physician may be used) completed by the child's physician is required.*

5. **Child requires medication while in care:** Answer "yes" or "no" as applicable.

*If answered "yes" a Medication Administration Form is required.*

6. **Other needs requiring assistance while in care:** Answer "yes" or "no" and check all boxes applicable then briefly describe the type of assistance that will be needed, if applicable.

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

**Early Intervention and Special Education:** Answer "yes" or "no" as applicable.

*If answered "yes" a parent may provide an Individual Family Service Plan (IFSP)/ Individualized Educational Program (IEP).*

**Exceptional Family Member Program (EFMP) Enrollment:** Answer "yes" or "no" as applicable.

*If answered "yes" a parent may provide the EFMP Enrollment Letter.*

**Sponsor's Signature:** Signature of Sponsor.

**Date:** Date sponsor signed form.

**DEFINITIONS:**

**"Food Allergy"** When a child has a food allergy, his or her body responds to food as if it were a threat. The body's immune system response can be mild or, in rare cases, associated with a severe and life-threatening reaction called anaphylaxis. Allergic reactions are highly unpredictable. The severity of one attack does not predict the severity of the next attack. The only way to prevent a life-threatening reaction is strict avoidance of the allergen.

**"Food Intolerance"** When a child has a food intolerance, it is a reaction of the digestive system and is not dangerous. Although a child may experience gas, bloating, abdominal pain and/or diarrhea, the reactions will pass and the child is not in danger. Children with food intolerances likely do not have prescribed medications for their condition, and do not need an EAP. Some common food intolerances are Lactose & Gluten.

NAVAL DISTRICT WASHINGTON  
CHILD & YOUTH PROGRAMS  
CHILD & YOUTH BEHAVIORAL MILITARY & FAMILY LIFE COUNSELING

MEMORANDUM FOR: Navy CYP Parents

**FROM:**

**SUBJECT:** Child and Youth Behavioral Military & Family Life Counseling (CYB-MFLC)

1. This letter is to inform you about the Child and Youth Military & Family Life Counseling (CYB-MFLC) Program services. Due to the unique challenges faced by military families, the Department of Defense is offering this private and confidential non-medical counseling service to military service members, military families, and military family service member's children in Child and Youth Programs (CYP), Department of Defense Education Activity (DoDEA) Schools, Local Education Agencies (LEA), DoDEA CYP summer programs, National Military Family Association Operation Purple Camps, Guard/Reserve Camps, and Operation Military Kids Camps
2. The CYB-MFLC may support the centers, schools, summer programs and camps and work with military children and their families in the following ways:
  - Observe, participate and engage in activities with children and youth
  - Provide direct interaction with military children
  - Model behavioral techniques and provide feedback
  - Suggest courses of age appropriate behavioral interventions to enhance coping and behavioral skills
  - Outreach to military parents when they drop off or pick up their children or at family events
  - Available for military parents to contact for guidance and support
  - Facilitate psycho-educational groups
  - Conduct training for staff and parents
  - Recommend referrals to military social services and other resources as needed
3. CYB-MFLCs may assist military parents, military children and centers with the following issues:

Communication	Self- esteem/self-confidence	
Resolving conflicts	Behavioral management techniques	
Bullying	Helping children deal with angry feelings	Sibling/parental
relationships	Deployment and reintegration issues	
4. The counselor may also work with military children in settings such as field trips and other center, camp, or school sponsored activities.
5. The counselor is available to accommodate appointments and meetings/activities after hours and on weekends with advance notice.
6. At no time will the counselor meet individually with a child without being in line of sight of a CYP, DoDEA, LEA, or camp employee or a parent/guardian.
7. The counselor may use only use OSD approved materials for trainings, groups, and any other activities.

Name of installation and/or CYP, school, summer program, and camp \_\_\_\_\_

I acknowledge that a CYB-MFLC is available and authorize my child \_\_\_\_\_ to receive CYB-MFLC support.

\_\_\_\_\_  
SPONSOR SIGNATURE

\_\_\_\_\_  
DATE

I acknowledge that a CYB-MFLC is available and **DO NOT** authorize my child \_\_\_\_\_ to receive CYB-MFLC support.

\_\_\_\_\_  
SPONSOR SIGNATURE

\_\_\_\_\_  
DATE

**MEAL BENEFIT APPLICATION  
CHILD CARE CENTERS: July 1, 2014 – June 30, 2015**

Complete this form so that we may receive reimbursement for meals served to children in our programs. For help call \_(301) 342-3902.

**PART 1 – ENROLLED CHILDREN INFORMATION**

Last Name	First Name	Check (✓) if foster child, homeless, migrant, runaway, or in head start. If <b>ALL</b> students listed are foster, homeless, migrant, runaway, or in Head Start, skip to Part 4.				
		Foster	Home	Migrant	Runaway	Head Start
1.						
2.						
3.						
4.						
5.						
6.						
7.						

**PART 2 - CASE NUMBER** - If applicable, give Food Supplement Program or Temporary Cash Assistance case number for **any** member of the household: \_\_\_\_\_ . **If completed, skip to Part 4. Last four digits of Social Security Number are not needed.**

**PART 3 - HOUSEHOLD MEMBERS AND GROSS INCOME.** You must tell us how much and how often.

LIST NAMES OF ALL HOUSEHOLD MEMBERS Include the child(ren) named above.	EARNINGS FROM WORK (before deductions)		ADDITIONAL INCOME Child Support, Alimony, TCA, Pensions, Retirement, Social Security, SSI, VA Benefits		ALL OTHER INCOME		Check if <b>NO</b> income
	Income	How Often	Income	How Often	Income	How Often	
1.	\$ .		\$ .		\$ .		<input type="checkbox"/>
2.	\$ .		\$ .		\$ .		<input type="checkbox"/>
3.	\$ .		\$ .		\$ .		<input type="checkbox"/>
4.	\$ .		\$ .		\$ .		<input type="checkbox"/>
5.	\$ .		\$ .		\$ .		<input type="checkbox"/>
6.	\$ .		\$ .		\$ .		<input type="checkbox"/>

**PART 4 - SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (ADULT MUST SIGN)**

An adult household member must sign the application. **If Part 3 is completed, the adult signing the form must list the last four digits of his/her Social Security Number, or check (✓) the “I do not have a SSN” box below.**

*I certify (promise) that all information on this application is true and that all income is reported. I understand that the center will receive Federal funds based on the information I give. I understand that center officials may verify (check) the information. I understand that if I purposely give false information, I may be prosecuted. I understand my child's eligibility status may be shared as allowed by law.*

Sign here: \_\_\_\_\_ Print name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Social Security Number: **XXX-XX-** \_\_\_\_ \_\_\_\_  I do not have a SSN

**PART 5 - (OPTIONAL) CHILDREN'S ETHNIC AND RACIAL IDENTITIES**

Choose one ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	Choose one or more (regardless of ethnicity): <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Black or African American
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**PART 6 - SHARING INFORMATION WITH OTHER PROGRAMS**

The eligibility status of your children may be used for other authorized purposes, shared with local Title I officials, and used for National Assessment of Educational Progress analyses. Your family may also be eligible to receive benefits under the Food Supplement Program (FSP) or the Women, Infants, and Children (WIC) Program.

To share your information with these programs, **we must have your permission.** Your decision will not change whether your children receive free or reduced-price meals. If you want information shared with FSP or WIC, check (✓) the YES box below. You may be contacted about submitting an application for the FSP or WIC.

**YES**, I want information shared from the Free and Reduced-Price Meal Benefit Application with  FSP and/or  WIC

Children eligible for free or reduced-price school meals may also be able to get free or low-cost health insurance through Medicaid or the MD Children's Health Insurance Program (MCHIP). The law allows us to inform Medicaid and MCHIP that your children are eligible for free or reduced price meals, unless you say No. Your decision will not change whether your children receive free or reduced-price meals. If you do **not** want information shared with Medicaid or MCHIP, check (✓)  No.

**DO NOT FILL OUT THIS PART. FOR CENTER 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: \_\_\_\_\_ Date Withdrawn: \_\_\_\_\_

Eligibility: Free \_\_\_\_ (Categorically Eligible: \_\_\_\_ )    Reduced \_\_\_\_    Denied \_\_\_\_    Reason: \_\_\_\_\_

Determining Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

June 30, 2014

Dear Parent/Guardian:

Children need healthy meals to learn. **The Child Youth Program** offers healthy meals every day. Although all children receive the meals at no charge, the U.S. Department of Agriculture (USDA) will provide Child and Adult Care Food Program (CACFP) funds that support the nutrition program based on your child's eligibility. This letter is a request for you to complete the information on the enclosed Meal Benefit Application to assist our agency's food service program.

1. DO I NEED TO FILL OUT AN APPLICATION FOR EACH CHILD? No. *Use one Meal Benefit Application for all children in your household.* We cannot approve an application that is not complete, so be sure to fill out all required information. Return the completed application to: **Child Development Center 22027 Cuddihy Road- Building 2183.**
2. ADDITIONAL USDA REIMBURSEMENT IS AVAILABLE TO OUR AGENCY FOR MEALS SERVED TO CHILDREN IN THE FOLLOWING HOUSEHOLDS:
  - Households receiving benefits from the Food Supplement Program (FSP) or Temporary Cash Assistance (TCA).
  - Foster children.
  - Households with a gross income within the free limits or reduced limits on the Federal Income Eligibility Guidelines (See Instructions for Applying).
  - Children certified as homeless, runaway, head start, or migrant.
  - Some households participating in WIC.
3. MY CHILD'S APPLICATION WAS APPROVED LAST YEAR. DO I NEED TO FILL OUT A NEW ONE? Yes. Your child's application is only good for one year. You must send in a new application each year.
4. WILL THE INFORMATION I GIVE BE CHECKED? Yes and we may also ask you to send written proof.
5. MAY I APPLY 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.
6. WHO SHOULD I INCLUDE AS MEMBERS OF MY HOUSEHOLD? You must include all people living in your household, related or not (such as grandparents, other relatives, foster children, or friends) who share income and expenses. You must include yourself and all children living with you. If you live with other people who are economically independent (for example, people who you do not support, who do not share income with you or your children, and who pay a pro-rated share of expenses), do not include them.
7. WHAT IF MY INCOME IS NOT ALWAYS THE SAME? List the amount that you normally receive. For example, if you normally make \$1000 each month, but you missed some work last month and only made \$900, put down that you made \$1000 per month. If you normally get overtime, include it, but do not include it if you only work overtime sometimes. If you have lost a job or had your hours or wages reduced, use your current income.
8. WE ARE IN THE MILITARY. DO WE INCLUDE OUR HOUSING ALLOWANCE AS INCOME? If you get an off-base housing allowance, it must be included as income. However, if your housing is part of the Military Housing Privatization Initiative, do not include your housing allowance as income.
9. MY SPOUSE IS DEPLOYED TO A COMBAT ZONE. IS HER COMBAT PAY COUNTED AS INCOME? No, if the combat pay is received in addition to her basic pay because of her deployment and it wasn't received before she was deployed, combat pay is not counted as income. Contact your child's school for more information.
10. MY FAMILY NEEDS MORE HELP. ARE THERE OTHER PROGRAMS WE MIGHT APPLY FOR? To find out how to apply for FSP, TCA, and medical assistance programs or other assistance benefits, contact your local assistance office or call 1-800-332-6347.

If you have other questions or need help, call **[301-342-3902]**.

Sincerely,  
**[Terry Davis]**