CARVER

Enlightening Generations

Carver Community Organization
400 S.E. 8th Street
Evansville, Indiana 47713
(812) 423-2612

- Summer Camp 2021 Application -

Before your child or children can begin the program, make sure the following forms are completed:

- Completed Summer Camp 2021 Program Application
- One-time activity fee of $60.00 per child to reserve your child's spot *(Non-Refundable) *
- Parent/Guardian's Pay Stubs (a month's worth of income)
- CCDF Voucher (if on program)
- Case Number (if any member of your household receives Food Stamps or State TANF assistance)

Return all completed applications to Ms. Jonelle Johnson at Carver Community Organization Monday through Friday from 8:30 am – 5:30 pm.

Contact information is (812) 423-2612 ext. 2201 and jajohnson@carverorg.org

Carver Community Organization, Inc.
400 S. E. 8th Street
Evansville, IN 47713
Phone: (812) 423-2612 Fax: (812) 423-6941
E-Mail: carverorg@carverorg.org

Youth Program Summer Camp Application

*A one-time activity fee of $60.00 is due with application (**Non-refundable)
$76.00 a week per child
Dates of Operation: Monday-Friday 6:00am—5:30pm
Pick up promptly at 5:30 pm
June 1st, 2021 — August 6th 2021

Child's Name: _____ Nickname(?): _____

Gender_____ Age_____ DOB___/___/_____ Grade_____

Name of School Attended: _____

Family Information

Mother/Guardian's Name: _____ Legal custody of child: ☐ YES ☐ NO

Address & Zip Code: _____

Home Phone: _____ Cell Phone: _____

Place of Employment: _____

Address & Zip code: _____ Work Phone: _____

Father/Guardian's Name: _____ Legal custody of child: ☐ YES ☐ NO

Address & Zip Code: _____

Home Phone: _____ Cell Phone: _____

Place of Employment: _____

Address & Zip code: _____ Work Phone: _____

List names of other children who attend Carver Day Care and Preschool (if applicable)

_____

Hours of Operation

6:00 am—5:30 pm

***LATE FEES APPLY AFTER 5:30 pm*

*Authorization for Pick-Up

We will not release your child to anyone without your authorization.

The following individuals have my authorization to pick up my child from childcare.

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

**If you wish to add or delete any of the individuals listed above, please complete another Authorization for Pick-Up Form.*

*Non-Authorized Pick-Up

The following individuals are specifically DENIED permission to pick up my child (if applicable):
*(If any individual listed is another parent of the child a court signed document is required.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

**To add or remove any of the individuals listed above, please contact Carver Community Organization at (812)423-2612*

_____ _____

Signature of Parent or Guardian Date

Emergency Contacts

Please list three (3) responsible adult persons who can be contacted in case parent(s)/guardian(s) cannot be reached in the case of an emergency:

Name: _____ Relationship: _____

Telephone #: _____ Alternate Phone #: _____

Employer: _____

Name: _____ Relationship: _____

Telephone #: _____ Alternate Phone #: _____

Employer: _____

Name: _____ Relationship: _____

Telephone #: _____ Alternate Phone #: _____

Employer: _____

Special Medical Health Need(s):_____

_____

_____

_____ _____

Signature of Parent or Guardian Date

Emergency Medical Authorization

*Local Telephones Numbers Required

I agree, and by my signature, give consent, that in case of an accident or illness of a serious nature, my child will be given emergency medical care, and if necessary, transported by ambulance. I understand that I will be contacted immediately, or as soon as possible should I be away from the phone numbers given with this application.

Name of Parent/Guardian: _____

Phone # 1: _____ Emergency#: _____

My child is insured: ☐ Yes ☐ No

In case of emergency, which hospital would you prefer your children to be transported?

_____

Physician's Name: _____

Physician's Phone Number: _____

Physician's Address: _____

City: _____ State: ___ Zip Code: _____

Dentist's Name: _____

Dentist's Phone Number: _____

Dentist's Address: _____

City: _____ State: ____ Zip Code: _____

_____ _____

Signature of Parent or Guardian Date

Behavior and Habits Form

1. How does your child react to other children? _____

   _____

2. How does your child react to adults? _____

   _____

3. How does your child react to new situations? _____

   _____

4. Is he/she insecure? _____ If so, please explain: _____

   _____

5. Does he/she show independence ☐ or dependence ☐?
6. What is your child's attitude toward discipline? _____

   _____

7. How does your child show fear? _____
8. What are some of the things that make your child afraid? (i.e.: the dark, heights, dogs, cats, etc.)

   _____

9. Does he/she share things willingly Yes ☐No ☐
10. Is he/she destructive? Yes ☐No ☐ If yes, please explain: _____

    _____

11. How does your child react to adults? _____
12. Is he/she friendly in most situations? Yes ☐No ☐ Shy? Yes ☐ No ☐

    Aggressive? Yes ☐No ☐ Withdrawn? Yes ☐ No ☐

13. How does your child reveal his/her feelings? _____

    _____

14. What makes your child upset? _____

    _____

15. Is there a pet in the household? Yes ☐No ☐

    If yes, how does your child react with the pet? _____

    If no, how does your child react to animals and pets? _____

Eating Habits

1. Does your child have any type of eating disorders? Yes ☐No ☐
   If so, please explain:_____
   _____
   _____

2. Does your child have any food allergies or food sensitivities? Yes ☐No ☐
   If so, please fill out the following chart, along with official document from Physician
   Food Allergens and Sensitivities
   If your child is allergic or sensitive to certain foods, please specify along with reactions:

_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
Signature of Parent or Guardian Date

Water Activities

1. Does your child know how to swim? Yes ☐ No ☐
2. Is your child able to swim more the 12.5 yards without assistance? Yes ☐ No ☐
3. Do you want your child to participate in swimming activities (including Swim Lessons)? Yes ☐ No ☐

_____ _____
Signature of Parent or Guardian Date

Allergies/Sensitivities

1. Does your child have any allergies or sensitivities? Yes ☐No ☐
   If so, please fill out the following chart, along with official document from Physician
   Allergens and Sensitivities
   If your child is allergic or sensitive to certain foods, please specify along with reactions:

_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
Signature of Parent or Guardian Date

DISCIPLINE AND GUIDANCE POLICY

Brief supervised separation from the group may be used if necessary, which is referred to as "reflection period". Most children are old enough to understand consequence both negative and positive.

Children shall not be humiliated or subjected to abusive or profane language. Punishment shall not be associated with food.

CAUSES OF DISMISSAL

1. Violent or threatening behavior (profane language, spitting, wild temper tantrums, etc...)
2. Child causing physical harm to themselves, other children, or staff (fighting, kicking, biting, etc...)
3. Child refusing to participate or cooperate in every segment of Summer Camp
4. Non-payment of required fees.

I understand the discipline guidance policy, with the understanding all camp proceedings are at the discretion of the Carver Community Organization Leadership Staff

_____ _____

Signature of Parent or Guardian Date

INTAKE AGREEMENT

LATE POLICY: A Carver staff member will attempt to call all persons/numbers listed on application in cases where the child has not been picked up by the end of the day's program (5:30). **Parents will be charged $10.00 for each ½ hour the child remains at the daycare. Payment due at arrival.**

If attempts have been made to contact you as well as the listed responsible adults and your child has not been picked up by 6:30 pm, Child Protective Services (425-2124) will be notified.

1. I understand that my child will only be released to the parent(s) named (pg. 2) or authorized (pg. 3)
   Yes ☐ No ☐
2. In case of serious injury or illness, I grant permission for emergency medical treatment
   Yes ☐ No ☐
3. I give the Carver Community organization and its designees to transport my child to and from field trips and other activities outside camp Facilities.
   Yes ☐ No ☐
4. I understand that payment for Summer Camp is due each Monday
   Yes ☐ No ☐
5. I understand I must supply the Summer Camp with my child's current Immunization Record prior to admission
   Yes ☐ No ☐
6. I understand that the Summer Camp staff will notify parent(s) of any issues pertaining to their child's performance
   Yes ☐ No ☐

_____ _____

Signature of Parent or Guardian Date

MEDIA RELEASE FORM

Dear Parent(s):

The United Way of Southwestern Indiana and various other funding sources, local newspapers and other organizations occasionally request photographs of the activities provided by Carver Community Organization, Inc.

We need a release from you, the parent / guardian, before releasing any photographs of your child to one of these funding sources or news media.

Thank you.

Please check one of the following statements.

☐ Yes, I give my permission for _____'s picture to be
Child(ren)'s name

taken and released for publicity.

☐ No, I do not give my permission for _____'s picture to be
Child(ren)'s name

taken and released for publicity.

_____ _____

Signature of Parent or Guardian **Date**

Parent - Provider Transportation Agreement

Child Care Program: **Carver Community Organization Summer Camp**

I, _____, give permission for my child care provider, or any approved
(Name of parent)

employee of the above program, to transport my child(ren) _____
(Name(s) of child(ren))

for the following reasons (check all that apply):

_____ Field trips

_____ Shopping

_____ Play dates

_____ Excursions to the park

_____ Emergency purposes

_____ Any reason deemed necessary by the program

It is agreed that:

1. The caregiver will never leave my child(ren) unattended in any motor vehicle or other form of transportation.
2. Each child will board or leave a vehicle from the curb side of the street.
3. My child(ren) will be secured in safety seats or by safety belts as appropriate for the age of the child(ren) in accordance with the law.
4. Any motor vehicle used to transport my child(ren) will have current registration and inspection stickers and must be operated by a person who is at least 18 years of age and possesses a valid driver's license.
5. The caregiver will notify me in advance of any instance where my child(ren) will be transported while in care.
6. The driver(s) is considered my employee or volunteer and therefore has met ALL CCDF Provider Eligibility Standards

_____ _____
(Parent or Guardian) (Date)

_____ _____
(Provider/Director) (Date)

IMPORTANT NOTICE!!
PERMISSION TO TRAVEL

Dear Parent / Guardian:

On _____, I will be taking your child(ren) to
(Date, including year)

_____ located at _____.
(Name of Place) (Address of Place)

We will leave at _____ and return at _____.

Your child needs to bring: _____.

Child's Name _____

Child's Name _____

Child's Name _____

I give my permission for my child(ren) listed above to go on _____
(Date)

to _____.
(Location of travel)

I understand my child will be transported safely using the appropriate equipment (car seat, booster seat or lap belt).

Parent / Guardian Signature: _____

FINANCIAL RESPONSIBILITY FORM

All fees are due and payable at the time of service. Fees for the current week are due no later than Friday by 5:30 p.m. If full payment on your account isn't received by the following Monday by noon, your account will be suspended, and Carver will not be able to accept your child for care the next day. All accrued fees must be paid before service can resume. You will be contacted by a Carver Staff Member to request payment of your account. You will have 30 days to respond. If you do not respond within the 30-day timeframe after being contacted for payment, your account will be turned over to a collection agency. We will set up a payment plan for clients who contact us to pay their past due fees if contacted before your account is turned over to a collection agency. However, you will be turned over to a collection agency if you do not keep your agreed payment arrangement. By signing below, you acknowledge your understanding and agreement of the terms for payment for services received from Carver Community Organization, Inc., and the collection procedure required for services received. By signing below, you also acknowledge that you are the person responsible for payment(s) to be made to Carver Community Organization, Inc.

I also understand that I am responsible for any attorney fees and court costs incurred in collecting and unpaid balances for services I received. I agree that this statement applies to all current and future claims.

_____ _____

Printed Name of person Financially responsible for child Date

_____ _____

Signature of person financially responsible Date

ATTESTATION

To the best of my knowledge, all the information provided herein is true and factual.

_____ _____

Signature of official completing form Date

Relationship to Child: _____

THIS IS A REQUIRED FORM

Day Care Provider Name _____

Child's Name _____ Date of Birth _____

Parent's Name _____ Phone _____

Address _____
Street Address City State Zip

Record Date of Immunization

	Birth	1 mo	2 mo	4 mo	6 mo	12-18 mo	2-3 yr	4-6 yr
Hep B								
DtaP / DTP / Td								
Hib								
MMR								
IPV								
Varicella								
PCV / Prevnar								
Hep A								

Child has documented history of Varicella Disease _____ No _____ Yes If yes, age _____

Please check the appropriate response.

☐ Child has received complete age-appropriate immunizations.

☐ Child is currently in the process of receiving complete age-appropriate immunizations.

ONE BOX ABOVE MUST BE CHECKED BY THE HEALTH CARE PROVIDER

Comments: *(Please list immunizations excluded for medical reasons)* _____

_____

Parent comments: (Please indicate religious objection, if any)

_____

_____

Signature _____ Date _____
(Medical Professional Signature and Date is required.)

Printed Name and Title _____
(Printed Name and Title is required)

This form must be updated annually.

INSTRUCTIONS FOR COMPLETING THE CACFP APPLICATION FOR FREE AND REDUCED PRICE MEALS (Child Care)

Follow these instructions, if your **household gets SNAP OR TANF**:

Part 1: List all household members and birth dates for children.
Part 2: List the case number for any household member (including adults) receiving Food Stamps or TANF.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form and enter the contact information. The last four digits of a Social Security Number are not necessary.
Part 6: Sign this part it you do not want your application information shared with Medicaid or Hoosier Healthwise.
Part 7: Answer this question if you choose.

If you are applying on behalf of a FOSTER CHILD, follow these instructions:

If all children you are applying for are foster children, or if you are only applying for benefits for the foster child:

Part 1: List all foster children**.** Check the box indicating that the child is a foster child.
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form and complete the contact information. A Social Security Number is not necessary.
Part 6: Sign this part it you do not want your application information shared with Medicaid or Hoosier Healthwise.
Part 7: Answer this question if you choose.

If some of the children in the household are foster children.

Part 1: List all household members. For any person, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster child.
Part 2: If the household does not have a case number, skip this part.
Part 3: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call [sponsor contact and phone number]. If not, skip this part.
Part 4: Follow these instructions to report total household income from this month or last month:

Section A – Name: List only the first and last name of **each** person living in your household with income, related or not (such as grandparents, other relatives, or friends who live with you). Include yourself and all children living with you. Attach another sheet of paper if you need to.

Section B – Gross Income and How Often it was Received: for each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month or monthly.
In Box 1 - list the **gross income,** not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.
In Box 2 - list the amount each person got from the month from welfare, child support, alimony.
In Box 3 - list retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits.
In box 4, list ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, under *Earnings From* Work, report income after expenses. This is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

INSTRUCTIONS FOR COMPLETING THE CACFP
APPLICATION FOR FREE AND REDUCED PRICE MEALS (Child Care)

Part 5: Adult household member must sign the form, complete the information, and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.
Part 6: Sign this part it you do not want your application information shared with Medicaid or Hoosier Healthwise.
Part 7: Answer this question if you choose.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:
Part 1: List all household members. For any person, including children, with no income, you must check the "No Income Box."
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Follow these instructions to report total household income from this month or last month:

Section A–Name: List only the first and last name of each person living in your household with income, related or not (such as grandparents, other relatives, or friends who live with you). Include yourself and all children living with you. Attach another sheet of paper if you need to.

Section B – Gross Income and How Often it was Received: for each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month or monthly.
In Box 1 - list the **gross income,** not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.
In Box 2 - list the amount each person got from the month from welfare, child support, alimony.
In Box 3 - list retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits.
In box 4, list ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, under *Earnings From* Work, report income after expenses. This is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: An adult household member must sign the form, complete the information, and list the last four digits of his or her Social Security Number, or mark the box if he or she doesn't have one.
Part 6: Sign this part it you do not want your application information shared with Medicaid or Hoosier Healthwise.
Part 7: Answer this question if you choose.

Privacy Act Statement: This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.

This institution is an equal opportunity provider.

Indiana
DEPARTMENT OF EDUCATION
Dr. Jennifer McCormick
Superintendent of Public Instruction
Working Together for Student Success

The United States Department of Agriculture has issued the following
INCOME ELIGIBILITY GUIDELINES effective **July 1, 2020- June 30, 2021**

Household Size	**Reduced-**Price Meals – 185%						**Free** Meals – 130%				
	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly		Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	23,606	1,968	984	908	454		16,588	1,383	692	638	319
2	31,894	2,658	1,329	1,227	614		22,412	1,868	934	862	431
3	40,182	3,349	1,675	1,546	773		28,236	2,353	1,177	1,086	543
4	48,470	4,040	2,020	1,865	933		34,060	2,839	1,420	1,310	655
5	56,758	4,730	2,365	2,183	1,092		39,884	3,324	1,662	1,534	767
6	65,046	5,421	2,711	2,502	1,251		45,708	3,809	1,905	1,758	879
7	73,334	6,112	3,056	2,821	1,411		51,532	4,295	2,148	1,982	991
8	81,622	6,802	3,401	3,140	1,570		57,356	4,780	2,390	2,206	1,103
For each add'l family member, add	8,288	691	346	319	160		5,824	486	243	224	112

THE TOTAL HOUSEHOLD INCOME STATED ON THE ENROLLED CHILDREN'S INCOME APPLICATION MUST BE COMPARED TO THE ABOVE GUIDELINES PRIOR TO THE SUBMISSION OF THE JULY CLAIM FOR REIMBURSEMENT FOR THE CURRENT FISCAL YEAR.

Following is the definition of income:
In accordance with the Department's policy as provided in the Food and Nutrition Service publication Eligibility Manual for School Meals, "income," as the term is used in this Notice, means income before any deductions such as income taxes, Social Security taxes, insurance premiums, charitable contributions and bonds. It includes the following: (1) monetary compensation for services, including wages, salary, commissions or fees; (2) net income from nonfarm self-employment; (3) net income from farm self-employment; (4) Social Security; (5) dividends or interest on savings or bonds or income from estates or trusts; (6) net rental income; (7) public assistance or welfare payments; (8) unemployment compensation; (9) government civilian employee or military retirement, or pensions or veterans payments; (10) private pensions or annuities; (11) alimony or child support payments; (12) regular contributions from persons not living in the household; (13) net royalties; and (14) other cash income. Other cash income would include cash amounts received or withdrawn from any source including savings, investments, trust accounts and other resources that would be available to pay the price of a child's meal.

"Income," as the term is used in this Notice, does not include any income or benefits received under any Federal programs that are excluded from consideration as income by any statutory prohibition. Furthermore, the value of meals or milk to children shall not be considered as income to their households for other benefit programs in accordance with the prohibitions in section 12(e) of the Richard B. Russell National School Lunch Act and section 11(b) of the Child Nutrition Act of 1966 (42 U.S.C. 1760(e) and 1780(b)).

If you have questions about the Income Eligibility Guidelines, please contact **Carol Markle** (cmarkle@doe.in.gov or 317-232-0873) or **Rachel Reynolds** (rreynolds@doe.in.gov or 317-232-0851).

This institution is an equal opportunity provider.

CACFP Application for Free and Reduced Price Meals (Child Care)

Sponsor Name:	**Phone Number:**
Center:	**FDC Provider:**

Part 1. All Household Members

Names of all household (First, Middle Initial, Last)	Birth Dates of Children	Check if a foster child (the legal responsibility of a welfare agency or court) * If all children listed below are foster children, skip to Part 4 to sign this form.	Check if NO income
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

Part 2. Benefits: If any member of your household received [Food Stamps] or [State TANF cash assistance], provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to Part 3.**

Name:_____ Case number: _____

Part 3. If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call [Insert center contact and phone number] Homeless ❑ Migrant ❑ Runaway❑

Part 4. Total Household Gross Income—You must tell us how much and how often **Check if NO income** ☐

A. Name (List **only** household members with income)	**B. Gross income and how often it was received** 1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the back of this 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 purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City:_____ State: _____ Zip Code: _____

Last four digits of Social Security Number: XXX - XX - __ __ __ __ ❑ I do not have a Social Security Number

_____ Initial here if you consent to allow [Provider's Name] to collect your form and provide it to the Sponsor. [Provider's Name] will not review your form.

Part 6: Other Benefits: The LAS allows us to tell Medicaid and Hoosier Healthwise that your children are eligible for free or reduced price meals. We may share your application information with Medicaid or Hoosier Healthwise unless you do not want us to. If you DO NOT want us to share this information, please sign here:

_____

Signature of Parent or Guardian

For Information about Hoosier Healthwise health insurance Call **1-800-889-9949**

CACFP Application for Free and Reduced Price Meals (Child Care)

A child enrolled in the day care facility may qualify for free or reduced price meals if the household income falls at or below the limits on this chart:

July 1, 2020 to June 30, 2021			
Household Size	Monthly Income	Household Size	Monthly Income
1	1,968	5	4,730
2	2,658	6	5,421
3	3,349	7	6,112
4	4,040	8	6,802
For each additional family member, add **$691**			

Part 7. Participant's Ethnic and Racial Identities (Optional)

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

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Child Care Representative Use Only

Annual Income Conversion: Weekly X 52 – Every 2 Weeks X 26 – Twice a Month X 24 – Monthly X 12

SECTION A *Mark one of the boxes below to show how you are going to determine eligibility.*

☐ **Food Stamp or TANF Household**—the Food Stamp or TANF number meets the criteria for an acceptable case number. Complete Section B & C **OR**

☐ **Foster Child**—Compare the foster child's personal income to the guidelines. Complete Section B & C **OR**

☐ **Household Income**—Complete the information below and Complete Section B & C

Total Household Size: _____

Total Household Income

$_____/_____

Example: $100/week

Compare total household income to current USDA Income Eligibility Guidelines. When the household incomes are listed for different pay periods, you must convert all income to monthly or annual income. Use the conversion listed above.

SECTION B

Based on the information provided, this application will be:

☐ approved free ☐ approved Tier I

☐ approved reduced ☐ approved Tier II

☐ paid

use this space for income calculation.

SECTION C

_____

Signature of Sponsor Representative

_____

Date of Approval

THIS FORM EXPIRES ONE YEAR FROM THE DATE IT WAS APPROVED

CHILD ENROLLMENT FORM

IDOE/CACFP
June 2019

Name of Institution: Sponsor ID Number:
Name of Facility:

Child's Name: **Birthdate:**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Please enter the normal hours your child is in care on the specific days of care.							
Please check (√) the meals your child normally receives while in care.	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__
If your school-age child will be in attendance outside of the regular hours indicated above (snow days, school breaks, etc.) Please check (√) here ______							

FOR INFANTS ONLY: All facilities must offer infant formula and meals/snacks to infants in care during meal service times

Infant Formula
This facility will provide the following iron-fortified infant formula: ____________________
Check here to accept: ☐ Check here to decline: ☐ Provide name of parent-provided formula: ____________________
Infant Meals and Snacks
Check here to accept: ☐ Check here to decline: ☐

This information is required by CACFP federal regulations at §226.15 (e)(2) and (3) for each enrolled participant, and must be updated annually.

Printed name of parent/guardian: Phone Number:

Signature of parent/guardian: Date:

This institution is an equal opportunity provider.

CARVER

Enlightening Generations

To whom it May Concern:

I hereby authorize and request that Carver Community Organization to be given the information specified, which is necessary to determine my family's income range based on CBDG (Community Development Block Grant) guidelines. This is without liability to me whatsoever and I may retain a copy of this authorization for my records.

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____

_____ _____

Signature of Parent or Guardian Date

Carver Community Organization, Inc.
400 S. E. 8th Street
Evansville, IN 47713
Phone: (812) 423-2612 Fax: (812) 423-6941
E-Mail: carverorg@carverorg.org

City of Evansville, IN – CDBG Participant Profile Form

1. **Participant Name:** _____
2. **Date of Birth:** _____
3. **Address:** _____
4. **Phone Number:** _____
5. **Race** (Pick One):

☐ White
☐ Black/African American
☐ Asian
☐ American Indian/Alaskan Native
☐ Native Hawaiian/Other Pacific Islander
☐ Asian & White
☐ Black/African American & White
☐ American Indian/Alaskan Native & White
☐ American Indian/Alaskan Native & Black
☐ Other Multi - Racial

6. **Hispanic Ethnicity** ☐ Yes ☐ No
7. **Female Headed Household** ☐ Yes ☐ No
8. **Military Veteran Household** ☐ Yes ☐ No
9. **Disability** ☐ Yes ☐ No

10. **Income Guidelines:**
    a. Step 1—Circle the number of persons in your household.
    b. Step 2—Circle your household income range (under the number you already circled in Step 1.)

	Number of Persons in Your Household							
2017 AMI Effective 6/13/17	**1 Person**	**2 Persons**	**3 Persons**	**4 Persons**	**5 Persons**	**6 Persons**	**7 Persons**	**8 Persons**
0-30%	$0-14,700	$0-16,800	$0-18,900	$0-20,950	$0-22,650	$0-24,350	$0-26,000	$0-27,700
31-50%	$14,701-24,500	$16,801-28,000	$18,901-31,500	$20,951-34,950	$22,651-37,750	$24,351-40,550	$26,001-43,350	$27,701-46,150
51-80%	$24,501-39,150	$28,001-44,750	$31,501-50,350	$34,951-55,900	$37,751-60,400	$40,551-64,850	$43,351-69,350	$46,151-73,800
Over 80%	$39,150+	$44,750+	$50,350+	$55,900+	$60,400+	$64,850+	$69,350+	$73,800+

DEFINITION OF A FAMILY: A family is defined as all persons living in the same household who are related by blood, marriage, or adoption, including adult children who continue to live at home with their parent(s) and a dependent child who is living outside of the home (e.g, students living in a dormitory). An individual living in a housing unit that contains no other person(s) related to him/her is considered to be a one person family for this purpose.

FAMILY INCOME: Income includes wages, salaries, tips; self-employment or business income, unemployment & disability income, retirement & insurance income, public assistance, interest & dividend income, alimony, child support, gift income, armed forces income for all family members 18 years of age and older.

I hereby certify that the information included on this form is correct to the best of my knowledge and that such information may be subject to verification by representatives of the City of Evansville and/or the United States Department of Housing and Urban Development for purposes of meeting the federal requirements of the Community Development Block Grant (CDBG) program.

BY MY SIGNATURE, I ACKNOWLEDGE THAT ALL INFORMATION I HAVE PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. According to Title 18, Section 1001 of the U.S. Code, it is a felony for any person to knowingly and willingly make false or fraudulent statement to any department of the United States Government. I AM AWARE THAT MAKING A FALSE STATEMENT TO OBTAIN BENEFITS TO WHICH I AM NOT ENTITLED IS A CRIME AND MAY SUBJECT ME TO BOTH CIVIL AND CRIMINAL PENALTIES.

Parent Signature: _____ **Date:** _____

City of Evansville, IN – CDBG-CV Participant Profile Form

1. **Participant Name:** _____
2. **Date of Birth:** _____
3. **Address:** _____
4. **Phone Number:** _____
5. **Race** (Pick One):

☐ White
☐ Black/African American
☐ Asian
☐ American Indian/Alaskan Native
☐ Native Hawaiian/Other Pacific Islander
☐ Asian & White
☐ Black/African American & White
☐ American Indian/Alaskan Native & White
☐ American Indian/Alaskan Native & Black
☐ Other Multi - Racial

6.	**Hispanic Ethnicity**	☐ Yes	☐ No
7.	**Female Headed Household**	☐ Yes	☐ No
8.	**Military Veteran Household**	☐ Yes	☐ No
9.	**Disability**	☐ Yes	☐ No

10. **Have you recently lost your job due to the COVID-19 Pandemic?** ☐ Yes ☐ No
    a. **Last date of work** _____
11. **Are you currently receiving Unemployment benefits?** ☐ Yes ☐ No
12. **Do you anticipate returning to work soon?** ☐ Yes ☐ No
    a. **Estimated date of return to work?** _____
13. **Are you currently unable to meet your family expenses?** ☐ Yes ☐ No
    a. **List current monthly expenses**
        i. **Rent/mortgage** _____
        ii. **Utilities** _____
        iii. **Insurance** _____
        iv. Other _____
14. **Are you receiving any other assistance to meet this need?** ☐ Yes ☐ No
    a. **Type of assistance / Example: rent, utility, mortgage etc.**_____
    b. **List other sources of assistance for above needs** _____
    c. **List months assistance has been provided** _____

SEE TABLE 1 TO CALCULATE ELIGIBLE EXPENSE IF APPLICABLE

15. **Income Guidelines:**
    a. Step 1—Circle the number of persons in your family.
    b. Step 2—Circle your family income range (under the number you already circled in Step 1.)
    NOTE: Income should include all household members regardless of relation

Number of Persons in Your Household								
2020 AMI Effective 4/08/20	**1 Person**	**2 Persons**	**3 Persons**	**4 Persons**	**5 Persons**	**6 Persons**	**7 Persons**	**8 Persons**
0-30%	$0-15,250	$0-17,400	$0-21,720	$0-26,200	$0-30,680	$0-35,160	$0-39,640	$0-44,120
31-50%	$15,251-25,400	$17,401-29,000	$21,721-32,650	$26,201-36,250	$30,681-39,150	$35,161-42,050	$39,641-44,950	$44,121-47,850
51-80%	$25,401-40,600	$29,001-46,400	$33,651-52,200	$36,251-58,000	$39,151-62,650	$42,051-67,300	$44,951-71,950	$47,851-76,600
Over 81%	$40,601+	$46,401+	$52,201+	$58,001+	$62,651+	$67,301+	$71,951+	$76,601+

DEFINITION OF A FAMILY: A family is defined as all persons living in the same household who are related by blood, marriage, or adoption, including couples living together, adult children who continue to live at home with their parent(s) and a dependent child who is living outside of the home (e.g., students living in a dormitory). An individual living in a housing unit that contains no other person(s) related to him/her is considered to be a one person family for this purpose.

FAMILY INCOME: Income includes wages, salaries, tips; self-employment or business income, unemployment & disability income, retirement & insurance income, public assistance, interest & dividend income, alimony, child support, gift income, armed forces income for all household members 18 years of age and older.

NOTE: The stimulus payments of $1,200 that were sent by the IRS under the CARES Act **do not** count as income. The extra $600 of unemployment benefit **does not** count as income, but the regular unemployment benefit **must be included as income**.

I hereby certify that the information included on this form is correct to the best of my knowledge and that such information may be subject to verification by representatives of the City of Evansville and/or the United States Department of Housing and Urban Development for purposes of meeting the federal requirements of the Community Development Block Grant (CDBG) program.

BY MY SIGNATURE, I ACKNOWLEDGE THAT ALL INFORMATION I HAVE PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. According to Title 18, Section 1001 of the U.S. Code, it is a felony for any person to knowingly and willingly make false or fraudulent statement to any department of the United States Government. I AM AWARE THAT MAKING A FALSE STATEMENT TO OBTAIN BENEFITS TO WHICH I AM NOT ENTITLED IS A CRIME AND MAY SUBJECT ME TO BOTH CIVIL AND CRIMINAL PENALTIES.

Participant Signature: _____ **Date:** _____

Disclaimer: This document has been created as a guide to determine gaps in need and identify any duplication of benefits.

TABLE 1 CALCULATIONS TO DETERMINE DUPLICATION OF BENEFITS AND ELIGIBLE EXPENSES

1. Identify applicants total need prior to assistance _____

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2. Identify all potential Duplicative Assistance
    a. FEMA Housing Grant (assumes interim housing is eligible use) _____
        i. Interim Housing *(e.g. rent)* _____
        ii. Permanent Housing (e.g. repair/rehabilitation) _____
    b. SBA Loan _____
    c. Insurance (Structure, not contents) _____

---

3. Deduct assistance determined to be duplicative
    a. FEMA Housing Grant (assumes interim housing is eligible use) _____
        i. Permanent Housing (e.g. repair/rehabilitation) _____
    b. SBA Loan _____
    c. Insurance (Structure, not contents) _____

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4. Maximum Eligible expense (Item 1 ***less*** Item 3) _____