Greetings from YWCA WNY! Thank you for choosing YWCA WNY as your Say Yes Buffalo Summer Camp partner. YWCA WNY has been operating summer camps for over 50 years, and has partnered with Say Yes Buffalo for the past 5 years. We are looking forward to an amazing summer full of learning and fun!

Attached you will find additional forms to be completed for our summer camp program. We understand it is lengthy, but multiple forms are required by Say Yes, our funders, and our NYS OCFS child care license. Thank you for taking the time to complete the forms. YWCA WNY Say Yes Summer Camp will run from Monday July 10th-August 18th, 2023, Monday-Friday from 8:30am-3:30 pm. YWCA WNY is open from 7:30am-5:30pm for both before and after care services. Should you need additional hours of care please be sure to note that on the application.

Due to COVID-19 guidelines, we cannot allow parents/guardians into our program space. A staff member will greet you upon arrival to complete the drop off process. If you would like additional information surrounding our COVID 19 protocols please request it when returning the application.

If you have any questions or concerns, please reach out to us using the contact information below. Looking forward to an amazing summer!

Best Regards,

Cherise Carson
Children & Youth Services Program Operations Manager
716-852-6120 ext. 116
ccarson@ywca-wny.org
All enrolled students are required to attend Monday-Friday from 8:30am-3:30pm. If you have a vacation planned please notify us as soon as possible. Say Yes allows up to 5 unexcused absences throughout the summer camp program. Unexcused absences include: vacation, staying home to go swimming, etc. Excused absences include: illness, COVID related absences, no transportation, Dr appointments, etc.

Before and After care is available from 7:30am-8:30am, and from 3:30 pm-5:30 pm at no cost if you meet the eligibility requirements. To be eligible, you must complete and return all forms included this packet, as well as provide proof of your work schedule which represents your need for the before and after care hours you are signing up for.

Student’s Name: ____________________________________________

Please check off the attendance schedule below for your child.

______ 8:30am-3:30 pm, my child will attend during Say Yes hours. I do not need before or after care.

______ My child will attend before and/or after care and their schedule will be as follows: Proof of my work schedule is attached.  
(For example- 8:00am-4:15pm) ____________________________________________________________

______ My family has a vacation planned for the upcoming summer. The dates my child will not be at summer camp are as follows: _______________________________________

Disclaimer:
I understand attendance at YWCA WNY Say Yes Summer Camp is required. I also understand that if my child has more than 5 unexcused absences, he/she will be removed from the program and placed on the waiting list.

Parent Name: ________________________________________________

Parent Signature: ____________________________________________ Date: ________
CHILD CARE EMPLOYEE, VOLUNTEER, PARENT, CHILD AND ESSENTIAL VISITORS
HEALTH SCREENING ONE-TIME ATTESTATION

Before entering a child care program, employees, volunteers, parents, children and essential visitors must complete a health screening questionnaire daily. In addition, each employee, volunteer, parent, child and essential visitor must sign and submit this form to the program one time. Employees, volunteers, parents, children and essential visitors must answer all questions and take their temperature daily to confirm a body temperature lower than 100.0 degrees Fahrenheit. If anyone answers “Yes” to any of the questions below, they cannot enter the child care program. A parent or guardian is responsible for completing daily screening on behalf of their child(ren).

Self-Screening:

Below are the self-screening questions that employees, volunteers, parents, children and essential visitors are required to answer daily. If any of the answers to the below questions are “Yes,” individuals cannot enter the program. If the answers are “No” to all the following questions, individuals may enter the program. If employees, volunteers, parents, children and essential visitors cannot take their temperature at home, but answer “No” to all other questions, they may report to the program to have their temperature taken on site.

1. Is your temperature higher than or equal to 100.0 degrees Fahrenheit?
2. Have you had any known contact with a person confirmed or suspected to have COVID-19 in the past 14 days?
3. Are you currently experiencing ANY of the following symptoms?
   - Cough (new or worsening)
   - Shortness of breath (new or worsening)
   - Trouble breathing (new or worsening)
   - Fever
   - Chills
   - Muscle pain (new or worsening)
   - Headache (new or worsening)
   - Sore throat (new or worsening)
   - New loss of taste
   - New loss of smell
4. Have you tested positive for COVID-19 through a diagnostic test in the past 14 days?

If you have answered “NO” to all questions, you have passed and may enter the program.

If you have answered “YES” to any question, you will not be allowed to enter the program.

Attestation: By signing this document, I agree that I will self-monitor these symptoms each day and report the outcome per the instructions above and will not enter any child care program if any of the above symptoms or conditions are present.

_________________________ / /
Signature

_________________________ / /
Date

_________________________ / /
Signature

_________________________ / /
Date

Note: This document must be signed and returned to the program prior to entry. A signed copy needs to be provided only once. The child care program must retain a copy for their records.
Assumption of the Risk and Waiver of Liability
Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

YWCA Western New York (“YWCA WNY”) has put in place preventative measures to reduce the spread of COVID-19; however, the YWCA WNY cannot guarantee that you or your child(ren) will not become infected with COVID-19. Further, attending the YWCA WNY could increase your risk and your child(ren)’s risk of contracting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that my child(ren) and I may be exposed to or infected by COVID-19 by attending the YWCA WNY and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at the YWCA WNY may result from the actions, omissions, or negligence of myself and others, including, but not limited to, YWCA WNY employees, volunteers, and program participants and their families.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to my child(ren) or myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my child(ren) may experience or incur in connection with my child(ren)’s attendance at the YWCA WNY or participation in YWCA WNY programming (“Claims”). On my behalf, and on behalf of my children, I hereby release, covenant not to sue, discharge, and hold harmless the YWCA WNY, its employees, agents, and representatives, of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of the YWCA WNY, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any YWCA WNY program.

__________________________________________
Signature of Parent/Guardian                      Date

__________________________________________
Name of Parent/Guardian                          Name(s) of YWCA WNY Program Participant
**NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES**

**DAY CARE ENROLLMENT**

**PHOTO OF CHILD (Optional)**

<table>
<thead>
<tr>
<th>Child's Full Name:</th>
<th>Date of Birth:</th>
<th>Gender:</th>
</tr>
</thead>
</table>

| Preferred Name/Nickname: | | |

<table>
<thead>
<tr>
<th>Child's Home Address:</th>
<th>Name of Person Enrolling Child:</th>
<th>Relationship to Child:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative ☐ Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone Number(s) of Person Enrolling Child:</th>
<th>Address of Person Enrolling Child (if different than child):</th>
</tr>
</thead>
<tbody>
<tr>
<td>( ) -</td>
<td></td>
</tr>
</tbody>
</table>

| OK to text | |

**EMERGENCY INFO**

<table>
<thead>
<tr>
<th>EMERGENCY CONTACT NAMES / ADDRESSES</th>
<th>Authorized to Pick Up</th>
<th>PRIMARY PHONE NUMBER</th>
<th>OTHER PHONE NUMBER / EMAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Contact:</td>
<td>☐ Yes ☐ No</td>
<td>☐ ok to text</td>
<td>☐ ok to text</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ ok to text</td>
<td>☐ ok to text</td>
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<td></td>
<td>☐ ok to text</td>
<td>☐ ok to text</td>
</tr>
</tbody>
</table>

**Check boxes below to indicate if your child has any special needs/services:**

- ☐ None
- ☐ Early Intervention/Special Education
- ☐ Occupational Therapy
- ☐ Speech/Language
- ☐ Physical Therapy
- ☐ Allergies (list) __________________________________________
- ☐ Other ____________________________________________________

Please provide information here AND discuss with your child care provider:

- Child's Primary Care Physician’s Name/Group: ____________________________
  Phone Number: ( ) -

- Preferred Hospital: ____________________________________________________
  Phone Number: ( ) -

- Child’s Dental Care: ____________________________
  Phone Number: ( ) -

Child health insurance information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: https://nystateofhealth.ny.gov/

**AGREEMENTS**

- I consent to emergency medical treatment for my child. ☐ Yes ☐ No
- I consent for my child to take part in neighborhood trips (i.e., library, park and playground) away from the program under proper supervision. ☐ Yes ☐ No
- I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips. ☐ Yes ☐ No
- I provided information on my child’s special needs to the program to assist in caring for my child. ☐ Yes ☐ No
- I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation. ☐ Yes ☐ No
- I agree to review and update this information whenever a change occurs and at least once every year. ☐ Yes ☐ No

**SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:**

<table>
<thead>
<tr>
<th>DATE:</th>
<th></th>
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</table>

*THIS FORM IS REQUIRED FOR ATTENDANCE, PLEASE FILL IT OUT COMPLETELY*
Authorized Pick Up List

Student Name: ________________________________

*You must list yourself, as the parent/guardian, as well.

ONLY the following people are approved to pick up this student: **YOU MUST INCLUDE YOURSELF AS THE PARENT:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone Number</th>
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<tbody>
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</tbody>
</table>

The following people **ARE NOT** allowed to pick up the student: (A copy of a restraining or court order is required)

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

Parent Signature: ________________________________ Date: ________________________________
Dear Parent, Guardian or CACFP Participant,

This center participates in the Child and Adult Care Food Program (CACFP) and provides healthy meals at no cost to all children and adults enrolled in the daycare center. By completing and returning the attached Income Eligibility Form, you will help your center receive money from CACFP for the meals that are served. If your household’s income is equal to or less than the amounts indicated for your household size on the chart below, the center will receive a higher rate of funding for the meals served. The Income Eligibility Form needs to be completed every year. Your center and CACFP will keep all information private.

INCOME ELIGIBILITY GUIDELINES
(Effective July 1, 2023 until June 30, 2024)

<table>
<thead>
<tr>
<th>HOUSEHOLD SIZE</th>
<th>REDUCED-PRICE MEALS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YEAR</td>
</tr>
<tr>
<td>1</td>
<td>26,973</td>
</tr>
<tr>
<td>2</td>
<td>36,482</td>
</tr>
<tr>
<td>3</td>
<td>45,991</td>
</tr>
<tr>
<td>4</td>
<td>55,500</td>
</tr>
<tr>
<td>5</td>
<td>65,009</td>
</tr>
<tr>
<td>6</td>
<td>74,518</td>
</tr>
<tr>
<td>7</td>
<td>84,027</td>
</tr>
<tr>
<td>8</td>
<td>93,536</td>
</tr>
<tr>
<td>FOR EACH ADDITIONAL FAMILY MEMBER</td>
<td>+9,509</td>
</tr>
</tbody>
</table>

This institution is an equal opportunity provider.
NEW YORK STATE DEPARTMENT OF HEALTH
Child and Adult Care Food Program

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME
YWCA of Western New York, Inc.

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

1. ____________________________________________  2. ____________________________________________  3. ____________________________________________

DIRECTIONS

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

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

SECTION A

SNAP Case # ____________________________________________
TANF # ____________________________________________
FDPIR # ____________________________________________
Names of Foster Children ____________________________________________

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

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

Signature ___________________________________________________________________________________

Date ___________________________

SECTION B

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

<table>
<thead>
<tr>
<th>HOUSEHOLD MEMBER NAME</th>
<th>MONTHLY GROSS SALARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. __________________</td>
<td>$ ________________</td>
</tr>
<tr>
<td>2. __________________</td>
<td>$ ________________</td>
</tr>
<tr>
<td>3. __________________</td>
<td>$ ________________</td>
</tr>
<tr>
<td>4. __________________</td>
<td>$ ________________</td>
</tr>
<tr>
<td>5. __________________</td>
<td>$ ________________</td>
</tr>
<tr>
<td>6. __________________</td>
<td>$ ________________</td>
</tr>
<tr>
<td>7. __________________</td>
<td>$ ________________</td>
</tr>
</tbody>
</table>

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

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

Signature ___________________________________________________________________________________

Print Name __________________________________________________________________________________

FOR SPONSOR USE ONLY

CACFP Agreement # __________________________
Total Number of Household Members ____________________________
(INCLUDING FOSTER CHILDREN, IF APPLICABLE)
Total Household Income $ ________________
Free ___________ Reduced ___________ Paid ___________
Date of Determination __________________________
Signature of Center Staff __________________________

USDA is an equal opportunity provider and employer.
**Privacy Act Statement:** The Richard B. Russell National School Lunch Act requires the information on this form. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the form. The Social Security Number is not required when you: apply on behalf of a foster child; provide a SNAP, TANF or FDPIR number; or when you indicate that the adult household member signing the form does not have a Social Security Number. We will use your information to determine if the center is eligible for free or reduced-price meal reimbursement and for administration and enforcement of the Program.

**INSTRUCTIONS FOR COMPLETING DOH-3688**

**Definition of Income**

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

**Definition of Household**

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

**INSTRUCTIONS FOR PARENTS OR GUARDIANS**

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

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

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

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

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

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

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

**INSTRUCTIONS FOR CENTERS AND SPONSORS**

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

**The CACFP Agreement Number**

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

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

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

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

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

My child, __________________________ will be attending YWCA of WNY, Inc. Children and Youth Services Programming at (circle the program):

School House Commons- Early Childhood Center

School House Commons- School Age Programming

Cleveland Hill Elementary School Age Programming

Teen Empowerment Program- JFK Recreation Center

Teen Empowerment Program- Crucial Community Center

He/She will be participating according to the following schedule:
Please circle the information that applies to your child’s participation.

Days per week: Monday Tuesday Wednesday Thursday Friday

Hours 8:30 am-3:30 pm- for all three meals.

Months per year SUMMER CAMP PROGRAM- July and August

Please circle the meals that your child will be served.

Breakfast Lunch Snack Supper/Dinner

Parent/Guardian signature Date
1. Household Income: Please check one from the below based on your income and the number of members living in your household.

<table>
<thead>
<tr>
<th>Income Limits</th>
<th>1 Person Household</th>
<th>2 Person Household</th>
<th>3 Person Household</th>
<th>4 Person Household</th>
</tr>
</thead>
<tbody>
<tr>
<td>30% median (XL)</td>
<td>$18,450 or less</td>
<td>$21,050 or less</td>
<td>$23,700 or less</td>
<td>$26,300</td>
</tr>
<tr>
<td>50% median (VL)</td>
<td>$30,700 or less</td>
<td>$35,100 or less</td>
<td>$39,500 or less</td>
<td>$43,850 or less</td>
</tr>
<tr>
<td>80% median (LI)</td>
<td>$49,150 or less</td>
<td>$56,150 or less</td>
<td>$63,150 or less</td>
<td>$70,150 or less</td>
</tr>
<tr>
<td>81-100% median</td>
<td>$54,400 or more</td>
<td>$62,100 or more</td>
<td>$69,900 or more</td>
<td>$77,600 or more</td>
</tr>
</tbody>
</table>

2. Individual Age: Please check one from the below based on your (or the participant’s) age.

- Under 5 years
- 5-9 years
- 10-15 years
- 16-20 years
- 21-24 years
- 25-44 years
- 45-54 years
- 55-61 years
- 62 and older

3. Gender: Please check one from the below based on the individual’s gender

- Male
- Female
- Other:

4. Are you of Hispanic ethnicity? Ethnicity and Race are different, please answer #5 as well:

- Yes
- No

5. Please check one race from the below chart

- White
- Black or African American
- Asian or Black or African American
- American Indian or Alaskan Native and White
- Asian
- American Indian or Alaskan Native and Black or African American
- Native Hawaiian or other Pacific Islander and White
- Native Hawaiian or other Pacific Islander and Black or African American
- Black or African American and White
- Other Multi Racial
- Asian and White

6. Do you (or the participant) have a severe disability?

- Yes
- No

7. Are one or both of your parents currently incarcerated?

- Yes
- No

8. Who do you (or the participant) live with?

- Both Parents
- Mother Only
- Father Only
- Self
- Student
- Other:

Certification (If participant is a youth, this form may be signed by a parent or guardian): I acknowledge that this information as submitted above has been examined by me and is true and correct.

Name or Initials: __________________________ Date: __________________________

Signature: __________________________