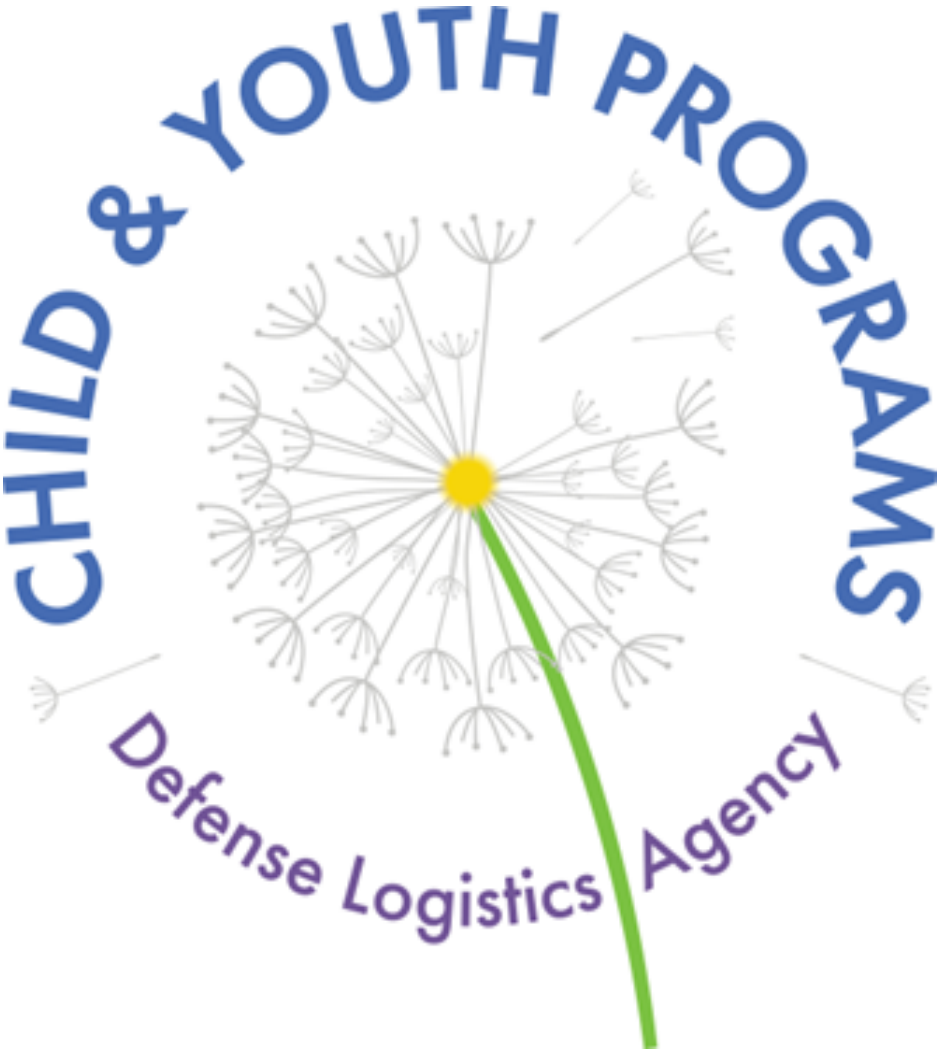

2025
Enrollment Packet

SECRETARY OF DEFENSE
1000 DEFENSE PENTAGON
WASHINGTON, DC 20301-1000

APR 2 3 2020

MEMORANDUM FOR CHIEF MANAGEMENT OFFICER OF THE DEPARTMENT OF DEFENSE
SECRETARIES OF THE MILITARY DEPARTMENTS
CHAIRMAN OF THE JOINT CHIEFS OF STAFF
UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS
CHIEFS OF THE MILITARY SERVICES
CHIEF OF THE NATIONAL GUARD BUREAU
GENERAL COUNSEL OF THE DEPARTMENT OF DEFENSE
INSPECTOR GENERAL OF THE DEPARTMENT OF DEFENSE
ASSISTANT SECRETARY OF DEFENSE FOR LEGISLATIVE AFFAIRS
ASSISTANT TO THE SECRETARY OF DEFENSE FOR PUBLIC AFFAIRS
DIRECTORS OF DEFENSE AGENCIES
DIRECTORS OF THE DOD FIELD ACTIVITIES

SUBJECT: Update to Child Care Policy Change Dated February 21, 2020

The purpose of this memorandum is to provide updates to the February 21, 2020 Policy Change Memorandum concerning child care priorities. My commitment to ensuring priority access to child care for military members remains unchanged.

I am directing that Coast Guard families be afforded the same priority as their DoD counterparts.

The attachment has been updated to reflect this change to Enclosure 3 of DoD Instruction (DoDI) 6060.02, "Child Development Programs;" changed text is bolded. The Washington Headquarters Services Directives Division will update the current version online.

Additionally, due to the challenges our families and child care programs are facing as a result of the COVID-19 pandemic, I am delaying the implementation date of the changes reflected in this memorandum, as well as the February 21, 2020 memorandum, to September 1, 2020.

The Under Secretary of Defense for Personnel and Readiness will ensure that any necessary conforming changes are made to DoDI 6060.02.

My point of contact is Carolyn Stevens, Director, Office of Family Readiness Policy, who may be reached at (571) 372-0867 or carolyn.s.stevens.civ@mail.mil.

Mark T. Esper

Attachment:
As stated

MILITARY CHILDCARE dot com

Military Family Types and DoD Priority

Families select their sponsor type (e.g., Active Duty Military, DoD Civilian) and spouse status (e.g., Working, Student, Seeking Employment, Non-Working) when they create or update their MCC household profile. MCC uses this information to create a military family type for the household, which is associated with a DoD priority. MCC uses the assigned DoD priority, along with the request for care date to determine sequence on the waitlist.

The chart below contains a complete list of all DoD priorities. You can use this chart as a quick reference when speaking to families about the DoD placement process or their specific DoD priority for care.

Military Family Type	Priority
CHILD DEVELOPMENT PROGRAM STAFF	
Child Development Program Staff	1A
ACTIVE DUTY COMBAT RELATED WOUNDED WARRIOR	
Combat Related Wounded Warrior*	1B.1
ACTIVE DUTY MILITARY/ACTIVE DUTY COAST GUARD	
Single/Dual Active Duty Military/Coast Guard	1B.2
With Full-Time Working Spouse	1B.4
With Part-Time Working Spouse	1C.1
With Spouse Seeking Employment	1C.1
With Full-Time Student Spouse	1D.1
With Non-Working Spouse	3A
GUARD/RESERVE ON ACTIVE DUTY OR INACTIVE DUTY TRAINING STATUS	
Single/Dual Guard/Reserve on Active Duty or Inactive Duty Training Status	1B.3
With Full-Time Working Spouse	1B.5
With Part-Time Working Spouse	1C.2
With Spouse Seeking Employment	1C.2
With Full-Time Student Spouse	1D.2
With Non-Working Spouse	3A
DOD/COAST GUARD CIVILIAN	
Single/Dual DoD or Coast Guard Civilian	2A
With Full-Time Working Spouse	2B
With Spouse Seeking Employment	3B
With Full-Time Student Spouse	3C
With Part-Time Working Spouse	3F
With Non-Working Spouse	3F

Military Family Type	Priority
GOLD STAR SPOUSE (COMBAT RELATED)	
Gold Star Spouse (Combat Related)	3D
DOD CONTRACTOR	
Singe/Dual DoD Contractor	3E
With Full-Time Working Spouse	3E
With Spouse Seeking Employment	3E
With Full-Time Student Spouse	3E
With Part-Time Working Spouse	3F
With Non-Working Spouse	3F
OTHER ELIGIBLE	
Deactivated Guard/Reserve Personnel	3F
Other Federal Employees	3F
Military Retirees	3F

1. *When Service members designated as combat-related wounded warrior in an Active Duty status require hospitalization, extensive rehabilitation, or significant care from a spouse or care provider and requires full-time child care, they may be placed into Priority 1B. This designation requires installation commander approval (this authority cannot be delegated).
2. Definitions: Full-Time and Part-Time Working
   a. Full-Time Working: Working 30 hours per week or 100 hours per month OR working less than 30 hours per week or 100 hours per month and enrolled in a post-secondary educational institution
   b. Part-Time Working: Working less than 30 hours per week or 100 hours per month
3. Guidance: Full-Time and Part-Time Student
   a. Full-time student status will be verified once an offer is made. The family may be asked to show documentation from the school verifying the full-time status during the eligibility verification process.
   b. Part-time students who are not working should select "Non-Working."

Ethnic and Racial Data Form

Agency/Daycare Center San Joaquin Child Development Center

Agency/Daycare Address 25600 S. Chrisman Rd. Bldg 32 Tracy, CA 95304

The agency or daycare listed above receives Federal financial assistance for participating in the Child and Adult Care Food Program (CACFP). Because they receive Federal financial assistance they are required to record and maintain the Ethnic and Racial data of all children enrolled in the CACFP. This information is used solely for the purpose of determining compliance with Civil Right laws and will be kept confidential. We are requesting for each participant to 'Self Identify' and provide this information, however it is optional to Self Identify. This ethnic and racial information will remain confidential and on file for 3 years and will only be accessible to authorized personnel.

To Self Identify, please answer the following questions.

Child's name:_____

Ethnic Category: Choose one

Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino".	
Non-Hispanic or Latino:	

Racial Categories: Check all that apply

American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America, (including Central America), and who maintains tribal affiliation or community recognition.	
Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.	
Black or African American: A person having origins in any of the black racial groups of Africa.	
Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.	
White: A person having origins in any of the original peoples of Europe, the Middle East or North Africa	
Other	

Parent/Guardian Signature_____ **Date**_____

DEFENSE LOGISTICS AGENCY
HEADQUARTERS
8725 JOHN J. KINGMAN ROAD
FORT BELVOIR, VIRGINIA 22060-6221

It is the mission of the San Joaquin Child Development Center to create a loving, caring and nurturing program as well as maintain an active learning environment for all of our age groups.

The Parent Handbook enables the Child Development Center to communicate the policies and procedures of our facility with you. By signing below you are acknowledging your receipt and understanding of the San Joaquin CDC's Parent Handbook.

Child's Name:_____ Parent Signature:_____

Date:_____

Thank you,

CDC Program Manager

DEFENSE LOGISTICS AGENCY
HEADQUARTERS
8725 JOHN J. KINGMAN ROAD
FORT BELVOIR, VIRGINIA 22060-6221

January 01, 2024

Credit Card Authorization

Please return back completed form to the front desk or e-mail to MWRSanJoaquinCDC@dla.mil

I, _____ (Card Holder Name), give the San Joaquin Child

Development Center authorization to charge my credit card for daycare related expenses.

Phone Number: _____

E-mail Address: _____

Your credit card information will not be saved in our system or on file. If making a phone payment, your credit card information will need to be provided each time. If you have any questions or concerns, please contact the center directly.

Printed Name: _____

Signature: _____

Consent to Perform Caregiving Health Practices and Authorization for Disclosure of Health Information

I (parent/guardian), _____, give permission to designated, trained Child, Youth, and School (CYS) Services personnel to perform and carry out caregiving health practices for my child/youth, _____, as outlined in my child/youth's Medical Action Plan (MAP) and ordered by the prescribing health care provider.

I acknowledge, and have discussed with my child's health care provider, the risks associated with the caregiving health practices that may be performed, and consent to trained CYS Services personnel performing certain accommodations outlined in my child/youth's MAP. I acknowledge that the risks to my child/youth could include death or permanent incapacitation.

I consent to CYS Services personnel responsible for performing caregiving health practices for my child/youth, to contact my child/youth's health care provider regarding the MAP and the administration of medication. I also authorize the disclosure/release of the information contained in my child/youth's MAP to all CYS Services personnel who have responsibility for my child and who may need to know this information to maintain my child's health and safety.

I acknowledge that the caregiving health practices performed by CYS Services personnel are being provided pursuant to 29 U.S.C. § 794, the Rehabilitation Act of 1973. Pursuant to 28 U.S.C. § 2680 and Army Regulation 27-20, Claims, dated 8 February 2008, paragraph 2-28, a tort claim against the U.S. Government is not payable if it is based upon an act or omission of an employee of the U.S. Government, exercising due care, in the execution of a statute or regulation, whether or not such statute or regulation is valid.

I understand that failure by the parent(s)/guardian(s) and/or child/youth to comply with CYS Services policies, guidelines, directions, regulations, and/or other applicable law may result in non-admission or removal of the child from CYS Services programs.

Parent/Guardian Name/Signature: _____ Date: _____

Printed Name of Parent/Guardian: _____

HEALTH ASSESSMENT/SPORTS PHYSICAL STATEMENT (HASPS)
for CYS SERVICES
ENROLLMENT, Renewal & SPORTS PHYSICAL Requirements

Revised 08Jan 09

DATA REQUIRED BY THE PRIVACY ACT OF 1994

PRINCIPAL PURPOSE: Information is used by DA personnel to: (1) verify child health status of immunization per admission requirements; (2) note special program considerations or restriction on child participation; (3) execute emergency medical procedure for chronic illnesses/conditions; (4) refer child for enrollment in Exceptional Family Member Program; (5) certify physically fit to participate in sports. **ROUTINE USES:** No information is disclosed outside DOD. **DISCLOSURE:** Information is voluntary; however, if information is not provided, individuals may not be able to participate in community activities.

INSTRUCTIONS: All sections A, B, C. must be completed

PART: A Medical History (Filled out by parent / guardian)

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

CHILD HEALTH INFORMATION

Name of Child	Birth Date	Sex ☐ Male ☐ Female

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

☐ Yes ☐ No

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

☐ Yes ☐ No

MEDICAL HISTORY

	YES	NO		YES	NO
1. Any hospitalization or operations			14. Heat stroke or exhaustion		
2. Allergies to medicine, insect bites or food			15. Broken bones or sprains		
3. Speech or development delays			16. Joint injuries (Ankle/Knee/Wrist)		
4. Vision Problems (Glasses / Contacts)			17. Required restricted physical activity		
5. Ear or hearing problems			18. Diabetes		
6. Seizures or Convulsions			19. Cancer		
7. Dizziness or fainting with exercise			20. Dental or orthodontic braces		
8. Headaches			21. Learning problems		
9. Head injury or loss of consciousness			22. Sleep problems		
10. Neck or back injury			23. Behavioral problems		
11. Asthma or difficulty breathing			24. ADD / ADHD		
12. Heart or blood pressure problems			25. Autism Spectrum Disorder		
13. Chest pain with exercise			26. Other (please list below)		

If you answer yes to any of the above, please explain:

Ongoing Medications

Name	Dosage	Frequency

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

Type	Reaction

PART B: Physical Exam

Medical Staff Assessment (Completed by licensed independent practitioner: Doctor-Dr., Nurse Practitioner-NP, Physician's Assistant-PA)

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

	NORMAL	ABNORMAL	N / A	COMMENTS
1. Eyes				
2. Ears, Nose & Throat				
3. Hearing				
4. Mouth & Teeth				
5. Neck (Soft tissues)				
6. Cardiovascular				
7. Chest & Lungs				
8. Abdomen				
9. Genitalia – Hernia				
10. Skin & Lymphatics				
11. Spine – Scoliosis				
12. Extremities				
13. Neurological				
14. Wears braces / plates				

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

Immunizations are current and up to date: ☐ Yes ☐ No

PARTICIPATION RECOMMENDATIONS

☐ All sports _____Yes _____ No ☐ Normal physical activity to including PE

☐ Additional comments: ☐ Restrictions:

Sports Physical is valid for 1 year from date indicated below

PART C

Special Medical Considerations: Describe any special program needs, considerations or restrictions which the child requires in order to participate in CYS programs (to include Sports).

Child / Youth is able to participate in normal CYS programs? ☐ Yes ☐ No

Date **Licensed Health Care Professional Stamp** **Licensed Health Care Professional; Dr., NP or PA Signature**

Initial Date **Type or print name of Parent or Guardian** **Signature of Parent or Guardian**

HASPS Renewal (Not Part of the Sports Physical)

Year 2 Date	**Health Status Changed**	**Signature of Parent or Guardian**
	☐ Yes ☐ No	
Year 3 Date	**Health Status Changed**	**Signature of Parent or Guardian**
	☐ Yes ☐ No	

ARMY CHILD AND YOUTH SERVICES HEALTH SCREENING – TOOL #1

PRIVACY ACT STATEMENT

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

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

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

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

SNAP Case Number: _____

FOR CER COMPLETION ONLY

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

Date in from Patron:

Date out to APHN:

Part A – General Information

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

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

Sponsor Name	Sponsor Government E-mail	Sponsor Personal Email
Spouse Name	Spouse Phone	Spouse E-mail
Home Phone	Cell Phone	Sponsor Unit/Duty Station
Home Address		Sponsor Duty Phone

Part B – Identification of Child/Youth Condition/Restrictions

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

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

Part C – Medications

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

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

Part D – Early Intervention and Special Education

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

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

Part E – Exceptional Family Member Program (EFMP) Enrollment

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

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

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

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

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

Form Updated 11 Mar 09

Child/Youth Name	Date of birth (YYYYMMDD)	Age

Part F – Release of Information

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

I understand that information disclosed pursuant to this authorization is For Official Use Only (FOUO) and may be subject to redisclosure. I understand that information redisclosed is no longer protected by DoD 6025, 18-R; however, confidentiality of this information will remain protected by the Privacy Act of 1974, 5 U.S.C. section 552a.

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

_____ _____

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

Part G – Army Public Health Nurse (APHN) Review

Current Medications other than those listed on page 1:

Diagnosis: _____

Background/Notes:

Medical Records Reviewed? ☐ No ☐ Yes ☐ Not Available

Training for CYS Staff/Provider Required:

Recommendation Summary:

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

Requirements Prior to Placement:

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

APHN Printed Name or Stamp	APHN Signature	Date (YYYYMMDD)

Date Received by APHN	Date Returned to CER:

Form Updated: 11 Mar 09

STANDARD COST FEE STRUCTURE - SCHOOL YEAR 2023-2024

SY 23-24 CHILD DEVELOPMENT CENTERS (CDC) MONTHLY FEE CHART
(2 Week Vacation Option)

Total Family Income Categories		Full Day
CAT 1	$1 - $45,000	$235
CAT 2	$45,001 - $55,000	$265
CAT 3	$55,001 - $65,000	$322
CAT 4	$65,001 - $77,500	$382
CAT 5	$77,501 - $90,000	$452
CAT 6	$90,001 - $102,500	$526
CAT 7	$102,501 - $115,000	$600
CAT 8	$115,001 - $130,000	$674
CAT 9	$130,001 - $145,000	$760
CAT 10	$145,001 - $160,000	$847
CAT 11	$160,001+	$934
DoD Contractors and Specifed Space Available	Not Applicable	$1,477

CHILD & YOUTH PROGRAMS
Defense Logistics Agency

STANDARD HOURLY RATE: $8.00
Multiple Child Reductions and Total Family Income Categories do not apply to Hourly Care.

ADDITIONAL INFORMATION

FINANCIAL DISCLOSURE: All patrons must disclose their total Family Income. Failure to disclose the Total Family Income will result in the denial of care.
MULTIPLE CHILD REDUCTION (MCR): 15% MCR is offered to the 2nd and subsequent children in regularly scheduled programs. Full fee is charged for the child in the most expensive care option, e.g., Full Day CDC care vs. SAC. 15% MCR is offered to 2nd and subsequent children in Youth Sports programs occurring during the same season. CAT 9 DoD Contractors and all approved Not Otherwise Authorized Patrons are not eligible for the MCR.
LATE PICK-UP FEES: Family fee of $1.00 per minute for first 15 minutes then $8.00 for next 45 mins. per child/site. If Family has children at different sites, late pick-up fees are assessed per site. Fee is payable before the child is readmitted to care.
LATE PAYMENT FEES: Payment for regularly scheduled Full Day, Part Day/Part Time and Before/After School Care is due by the 5th business day of the payment cycle. For services billed twice a month (1st and 15th), a one-time $10.00 per child late payment fee will be assessed on the 6th business day of each missed payment cycle. For any regularly scheduled activities billed on a monthly basis, a one-time late payment fee of $20.00 per child will be assessed on the 6th business day after the 1st of the month billing.
***PART TIME CARE:** Applies to specialized Part Time programs; includes Part Time Kindergarten care (for children attending a part day [AM or PM] Kindergarten program).
****PART DAY ENRICHMENT:** Also applies to Installations that operate on a 4 day a week schedule (e.g. 4 Day 3.5 Hrs.)

STANDARD COST FEE STRUCTURE - SCHOOL YEAR 2023-2024

SY 23-24 CHILD DEVELOPMENT CENTERS (CDC) MONTHLY FEE CHART
(4 Week Vacation Option)

Total Family Income Categories		Full Day
CAT 1	$1 - $45,000	$245
CAT 2	$45,001 - $55,000	$277
CAT 3	$55,001 - $65,000	$336
CAT 4	$65,001 - $77,500	$399
CAT 5	$77,501 - $90,000	$472
CAT 6	$90,001 - $102,500	$549
CAT 7	$102,501 - $115,000	$626
CAT 8	$115,001 - $130,000	$703
CAT 9	$130,001 - $145,000	$793
CAT 10	$145,001 - $160,000	$884
CAT 11	$160,001+	$975
DoD Contractors and Specifed Space Available	Not Applicable	$1,542

CHILD & YOUTH PROGRAMS
Defense Logistics Agency

STANDARD HOURLY RATE: $8.00
Multiple Child Reductions and Total Family Income Categories do not apply to Hourly Care.

ADDITIONAL INFORMATION

FINANCIAL DISCLOSURE: All patrons must disclose their total Family Income. Failure to disclose the Total Family Income will result in the denial of care.
MULTIPLE CHILD REDUCTION (MCR): 15% MCR is offered to the 2nd and subsequent children in regularly scheduled programs. Full fee is charged for the child in the most expensive care option, e.g., Full Day CDC care vs. SAC. 15% MCR is offered to 2nd and subsequent children in Youth Sports programs occurring during the same season. DoD Contractors and Specified Space Available Patrons are not eligible for the MCR.
LATE PICK-UP FEES: Family fee of $1.00 per minute for first 15 minutes, then $8.00 for next 45 mins. per child/site. If Family has children at different sites, late pick-up fees are assessed per site. Fee is payable before the child is readmitted to care.
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*PART TIME CARE: Applies to specialized Part Time programs; includes Part Time Kindergarten care (for children attending a part day [AM or PM] Kindergarten program).
**PART DAY ENRICHMENT: Also applies to Installations that operate on a 4 day a week schedule (e.g. 4 Day 3.5 Hrs.)

Parent/Guardian's Form for Declining a Provider's Infant Formula or Food

All child care facilities (providers and centers) participating in the Child and Adult Care Food Program (CACFP) are required to offer at least one infant formula which meets the definition of infant formula according to federal guidelines, unless breast milk is being provided by the infant's parent. The provider or center has selected a formula that complies with the federal guidelines. In addition, infants whom are developmentally ready to consume solid foods must be offered according to the CACFP meal pattern.

As a parent/guardian, you choose to decline the provider's or center's offered infant formula or food component and will furnish a formula or food component that meets the CACFP meal pattern requirements, unless your doctor has prescribed a special formula/food. **If your physician, physician assistant, or nurse practitioner's prescribed formula or food item(s) that does not meet the CACFP requirements, you will need to have them complete Form ID CNP 925 Medical Statement to Request Special Meals and/or Accommodations.** Return the original to your provider or center. Please complete the form below in order to allow your provider or center to receive CACFP meal reimbursement. **(Provider: Please keep a copy in the child's file and forward the original to your CACFP sponsor.)**

Infant's Last Name **Infant's First Name**

Name of Formula/Food Component Offered by Provider or Center

Similac Advance

Formula/Food Component Parent/Guardian Chooses to Provide

If Formula, is it Iron Fortified? ☐ **Yes** ☐ **No**

Parent/Guardian's Reason for Substitution

Parent/Guardian's Signature **Date**

Provider/Center's Response to Parent/Guardian's Request

Provider/Center's Signature **Date**

U.S. Department of Agriculture (USDA) Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or

2. Fax: (833) 256-1665 or 202-690-7442; or

3. Email: program.intake@usda.gov

This institution is an equal opportunity provider.

CHILD & YOUTH PROGRAMS
Defense Logistics Agency

Child and Youth Programs

Infant Sleep Position Agreement

I, the undersigned, as the parent/guardian of_____have read and understand the information provided to me with this agreement. I agree and have designated the sleep position for my infant when receiving care in CY Programs. In addition, I agree to have this information attached behind my child's photo posted on or above my child's crib.

Please check one:

☐ My infant will be placed in a CYP Sleep Sack (temperature permitting) on his/her back as recommended by the American Academy of Pediatrics (AAP). All blankets and stuffed toys will be removed from my infant's crib.

☐ My infant has a special medical condition and my child's physician has provided written sleep instructions. My child will be placed in a CYP Sleep Sack (temperature permitting) and all blankets and stuffed toys will be removed from my infant's crib.

These instructions, signed by my child's physician, are attached to this Infant Sleep Position Agreement.

Infant's Date of Birth:
Parent/Guardian Signature:
Printed Name:
Address:
Home Phone:
Work Phone:
Email:
Date:

CHILD & YOUTH PROGRAMS
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Child and Youth Programs

Infant Sleep Position Agreement

Sudden Infant Death Syndrome (SIDS) is defined as the sudden and unexplained death of an infant under one year of age. SIDS, sometimes known as "crib death," strikes nearly 3,500 babies in the U.S. every year. Deaths are sudden and unpredictable. In most cases, the baby seems healthy.

The American Academy of Pediatrics (AAP) reports that one of the most important things to help reduce the risk of SIDS is to put healthy babies on their backs to sleep. This is done when a baby is being put down for a nap, rest, or sleep for the night.

Between the ages of 6 months to 12 months, infants may begin to turn over on their own. Once this occurs, infants assume their own sleep positions after first being placed on their backs to sleep. Staff will not reposition infants who roll over independently.

To reduce the risk of SIDS, Child and Youth Program Assistants will:

- Ensure that crib mattresses are firm and covered by a fitted sheet.
- Remove all soft objects and loose bedding from cribs (such as pillows, blankets and stuffed toys) .
- Place infants in wearable CYP Sleep Sacks.
- Watch to see that infants do not become overheated.
- Provide adult supervised "tummy time activities" when infants are awake to ensure upper body muscle development and to help prevent flat spots on the back of the head. Note: Tummy time activities are provided outside of the crib, e.g., in safe places where infants can listen, observe, and interact with others in their environment. An adult must be in close physical contact with infants during this time and be constantly aware of the infants' movements and activities. Infant will be placed on a plastic mat (plastic/vinyl) or activity mat (cloth). Blankets will not be used, and infants are not to be placed directly on a carpet.
- Place infants to sleep with their heads to one side for a week and then on the other side to prevent misshaping of the head.

Infant sleeping areas in all CYP settings will be well lighted and co-located with infant activity areas so that line of sight adult supervision is maintained. Separate and/or darkened rooms/crib areas are not authorized.

In addition, AAP information for parents/guardians includes avoiding:

- Extensive time in infant carriers or "bouncers" to ensure upper body muscle development.
- Exposure of infants to second hand smoke.
- Use of home monitors or commercially marketed "SIDS reducing devices" as a strategy to reduce the risk of SIDS. There is no evidence that the use of such products reduce the risk.
- Bed sharing or co-sleeping e.g., on sofas or beds, with other infants or adults. Do not place a baby on a waterbed, sofa, soft mattress, pillow, or other soft surface.

For more information on reducing the risk of SIDS, contact the American Academy of Pediatrics at www.aap.org or the National Institute for Child Health and Human Development www.nichd.nih.gov/sids/sids.cfm