SCOTT COUNTY FAMILY Y

Summer Camp Programs - Registration Packet 2020

Please choose your site:

Camp Abe Lincoln

☐ Day Camp/Kinder Camp ☐ Overnight Camp/Teen Camp/Specialty Camp

(See last page of this registration packet for Camp Abe Lincoln's weekly themes, rates and additional information.)

Summer Camp locations accepting State Child Care Assistance:

☐ Bettendorf Y ☐ Davenport Y ☐ North Y ☐ Riverdale Heights Elementary School ☐ West Y TBK

$25 Registration fee and this registration packet completed with immunization records required before weekly registration available. If applying for State Assistance, would like to apply for income based pricing available or weekly draft of your program fees, contact Amanda at 563.323.5730.

This registration packet must be completed for all Summer Camp participants.

Child's Name:		**CHILD's School:**
Address:		**Grade Completed:**
City:	**State:**	**Zip:**
Primary Guardian's Name:		**Email:**
Primary Ph#:		**Alternative Ph#:**
Secondary Guardian's Name:		**Email:**
Primary Ph#:		**Alternative Ph#:**
Birth date:	**Age:**	**Sex** ☐ **M** ☐ **F**

In Case of Emergency and Authorized Pick Up

Persons to contact in case of emergency if parents are unavailable and are authorized to pick the child up.

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

If there are any custody or restraining orders for person(s) who may attempt to pick up or have contact with the child(ren) while in care at the center, please list the names of the person(s). If there is a custody or restraining order in place, we will need a copy of the document for the file.

COMPLETE ONLY IF ATTENDING SUMMER ADVENTURES OR SUMMER FUN CLUB:

The following information is required by the Child and Adult Care Food Program the Y participates in.

My child's usual days and times of attendance will be:

Monday ☐	Tuesday ☐	Wednesday ☐	Thursday ☐	Friday ☐
Arriving at	Arriving at	Arriving at	Arriving at	Arriving at
Leaving at	Leaving at	Leaving at	Leaving at	Leaving at

My child's anticipated meal participation will be:

☐ Breakfast ☐ Lunch ☐ PM Snack

Ethnicity/Racial Identity of Child (Answering this question is voluntary)

Hispanic or Latino	Non-Hispanic or Latino	American Indian	Alaskan Native	Asian	White	Black or African American	Pacific Islander or Native Hawaiian
☐	☐	☐	☐	☐	☐	☐	☐

SUBMIT COMPLETED REGSTRATION PACKET:

- **Email to CCPacket@scottcountyfamilyy.org or fax to Amanda Dang @ 563.323.1922 or drop off at any Scott County Family Y branch or YMCA Kids Club site or Camp Abe Lincoln**

Child Name : ___________________________

Waiver of Liability

I understand that I am able and am speaking on behalf of myself and other individuals listed on this application. In consideration of my/our participation in the Scott County Family Y program(s) I/we do hereby agree to hold free from any and all liability the YMCA and it's respective officers, employees, and members and do hereby for myself/ourselves, my/our heirs, executors, and administrators, waive, release, and forever discharge any and all rights and claims for damages that I/we may hereafter accrue to me/us arising from, or connected with myself/ourselves to be physically sound having medical approval to participate in the childcare program of the YMCA.

Transportation and Activity Authorizations

I give permission for my child to participate in trips, tours, walks, and special events under the supervision of YMCA staff. Notifications of any activity will be given in advance of said activity. Please note that all Y activity classes that a child has signed up for will be considered a field trip from the center. The Y staff involved in teaching the class is/ are not considered a member of the childcare staff. I further understand the childcare staff will be responsible for preparing each child for lessons including assisting with changing clothes if the class requires special clothing (swim suits, gymnastic outfits, etc.). Children will be supervised at all times and no child will be allowed to go to or from any activity class without the supervision of a staff person from the childcare department.

Parent Payment Agreement

Tuition for all programs is due in advance each Friday for the next week of service. There will not be any deductions for absence or holidays. Summer Camp Programs are paid on a weekly basis. We do not offer part time care in any of our programs. Parents are required to pay an annual registration fee of $25.00. Families will be charged a late pick up fee of $5.00 per every 15 minutes after program end time. There will be an additional fee in the event of a returned check. Weeks of absence must be reported the Wednesday prior to avoid being responsible for that week's program fees. In case of withdrawal of my child from the program, I agree to give the center a two week notice.

Photography Consent

I ☐ DO or ☐ DO NOT give consent to let my child be photographed for use by the YMCA in newspapers or other media for the purpose of advertisement or publicity.

First Aid Consent

I give my permission for staff to give first aid or apply antiseptic ointment if it is deemed necessary.

Permission to Apply Sunscreen to Child

As the parent/guardian of the above child, I recognize that too much sunlight may increase my child's risk of getting skin cancer someday. Therefore, I give my permission for personnel at the **Scott County Family Y** to apply a sunscreen product of SPF-15 or higher to my child, as specified below, when he/she will be playing outside during the months of March through October and between the daily times of 10 a.m. and 4 p.m.. I understand that sunscreen may be applied to exposed skin, including but not limited to the face, tops of the ears, nose, and bare shoulders, arms, and legs. I have checked all applicable information regarding the type and use of sunscreen for my child:

- ☐ I do not know of any allergies my child has to sunscreen
- ☐ Staff may use the sunscreen of their choice following the directions or recommendations printed on the bottle
- ☐ I have provided the following brand/type of sunscreen for use on my child:___________________________
- ☐ My child is allergic to some sunscreens. Please only use the following brand(s) and type(s) of sunscreen: ____
- ☐ For medical or other reasons, please do not apply sunscreen to the following areas of my child's body__________________________________

Parent/Guardian full legal name (print): ____

Parent/Guardian signature: ____**Date:** ____________

I understand that by typing my name above, I am electronically signing.

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Scott County Family Y
Summer Camp Programs
Code of Conduct

The code of conduct for the Scott County Family Y Summer Camp Programs defines expectations for all participants to ensure that all participants are safe and to reduce disciplinary problems. A disciplinary problem is defined as one in which a child is hampering the smooth flow of the program by either requiring constant one on one attention; is inflicting physical or emotional harm on other children; is physically or verbally abusing staff or is otherwise unable to conform to the rules and guidelines of the program.

Child's Name:____

1. Check in to the YMCA Summer Camp Program upon arrival to site.
2. Do not bring personal belongings to the YMCA Summer Camp Program.
3. Remain seated and quiet during role call and announcements. Answer only for myself.
4. Follow all YMCA Summer Camp Program rules.
5. Follow all instructions given by the YMCA Summer Camp Program staff.
6. Respect all other children and the YMCA Summer Camp Program staff at all times.
7. Respect all YMCA Summer Camp Program and park or business supplies, equipment and property.
8. Help in cleaning up after myself in all activities.
9. Never leave the YMCA Summer Camp Program site or assigned group without permission from a YMCA Summer Camp Program staff member.
10. Follow the Time Out instructions of the YMCA Summer Camp Program staff For each code of conduct violation there may be a 5 – 15 minute Time Out, up to 3 Time Outs per day. Parents will be called to pick up any participant that receives more than 3 Time Outs.

My signature below indicates that I have read and understand the expectations of the YMCA Summer Camp Program; and that I will abide by the rules listed above.

Child's Signature:____ Date:________________
I understand that by typing my name above, I am electronically signing.

My signature below indicates that I have read and understand the expectations for the YMCA Summer Camp Program; and I support my child abiding by these rules.

Parent's Signature: ____ Date:________________
I understand that by typing my name above, I am electronically signing.

School-Age Child Health From/Parent Statement of Health

Parent/Guardian please complete

Child's Name:	Child's Birth date:	Name of School: Grade: School Phone:
Parent/Guardian Name (#1):	Parent/Guardian Name (#2):	
Child's Home Address (#1):	Child's Home Address (#2):	Phone (#1): Phone (#2):
Parent/Guardian (#1) Place of Employment:	Work Address (#1):	Work Phone (#1): Email:
Parent/Guardian (#2) Place of Employment:	Work Address (#2):	Work Phone (#2): Email:

In the event of an emergency, the child care provider is authorized to obtain EMERGENCY MEDICAL or DENTAL CARE even if the child care facility is unable to immediately make contact with the parent/guardian.

☐ Yes ☐ No

During an emergency, the child care provider is authorized to contact the following person when the parent or guardian cannot be reached.

Parent/Guardian Signature:____ Date:______________

I understand that by typing my name above, I am electronically signing.

Alternate Emergency contact person's name: __________________________________Phone: (____) ____-______

Relationship to Child: ______________________________ Additional Phone: (_____) ____-______

Child's **Doctor's** Name:	Doctor's Phone:	Hospital of choice:
Doctor's address:	After hours telephone:	Does your child have health insurance? ☐ Yes ☐ No Company: ID #:
Child's **Dentist's** Name:	Dentist's Phone:	Does your child have dental insurance? ☐ Yes ☐ No Company: ID #:
Dentist's address:	After hours telephone:	☐ Help us find a family doctor or dentist ☐ Help us find health or dental insurance
Other health care/mental health specialist name:		Phone:

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School-Age Child Health From/Parent Statement of Health (cont.)

Check the statements that apply to your child:

Child's name:____

Date of Child's Last Physical Exam:

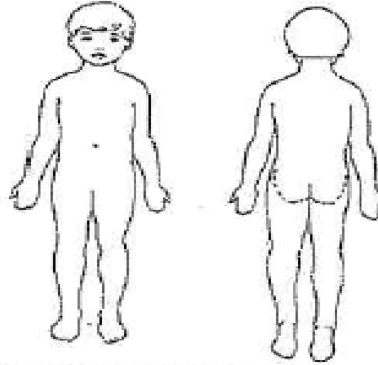
Growth
☐ I am concerned about my child's growth
Appetite
☐ I am concerned about my child's eating habits
Rest
☐ My child needs to rest after school
Illness/Surgery/Injury
☐ My child had a serious illness, surgery, or injury
Please Describe:
Physical Activity - My child
☐Must Restrict physical activity or needs special equipment to be active. Please describe

Play with friends – My Child
☐ Plays well in groups with other children
☐ Will play only with one or two other children
☐ Prefers to play alone
☐ Fights with other children
☐ I am concerned about my child's play activity with other children
School and Learning – My child
☐ Is doing well at school
☐ Is having difficulty in some classes
☐ Does not want to go to school
☐ Frequently misses or is late for school
☐ I am concerned about how my child is doing
☐**Allergy -** My child has allergies (Medicine, food, dust, pollen, insects, animals, etc.
List Allergies:

☐**Special Needs Care Plan –** My child has a special needs care plan (IEP, Asthma Action Plan, Food Allergy Plan, etc.) Please discuss with your health care provider.

Date of Child's Last Dental Appointment:

Body Health – My child has <u>problems</u> with
☐ Skin, hair, fingernails or toenails
Describe skin marks, birthmarks, or scars. Show us where these skin marks are located using the drawing below:



☐Eyes/Vision, glasses or contact lenses
☐Ears/hearing, hearing assistive aides or device, earache, tubes in ears
☐Nose problems, nosebleeds
☐Mouth, teeth, gums., tongue, sores in mouth or on lips, breaths through mouth
☐Frequent sore throats/tonsillitis
☐Breathing problems, asthma, cough
☐Heart problems or heart murmur
☐Stomach aches or upset stomach
☐Trouble using toilet or wetting accidents
☐Hard stools, constipation, diarrhea, watery stools
☐Bones, muscles, movement, pain when moving
☐Mobility, child uses assistive equipment
☐Nervous system, headaches, seizures, or nervous habits (like twitches or tics)
☐Females – difficult monthly periods
☐Other special needs: Please describe

Parent Signature ____ **Date** __________________

I understand that by typing my name above, I am electronically signing.

**A completed copy of the
Iowa Department of Public Health
Certificate of Immunization
form for your child must be received
before weekly registration is allowed.**

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Iowa Eligibility Application

FFY 19-20

Complete one application per household. School Year 2019-2020

Part 1. Check all applicable boxes:

- ☐ school meals
- ☐ special milk (restrictions apply)
- ☐ children in child care center
- ☐ Tier I home provider (HP)
- ☐ Head Start/Even Start
- ☐ children in child care home(HP) Provider name:

Part 2. Check if any child is Homeless, Migrant, or a Runaway and call your child's school. ☐ Run away ☐ Migrant ☐ Homeless

Part 3. FIP or Food Assistance Eligible: Enter the FIP or Food Assistance Case Number for ANY household member as listed in the Notice of Decision. NOTE: Medicaid, Title XIX and EBT card numbers are not acceptable. Skip part 5.

Name of household member with Case Number ______________________ List Case Number ______________________

Part 4. Children enrolled. REQUIRED OF ALL APPLICANTS.

List name(s) of all enrolled child(ren) in your household.

Last Name	First Name	Middle Name or Initial	Check box for FOSTER child	Date of Birth	Grade	OPTIONAL: ETHNICITY	OPTIONAL: RACE	Name of School/Head Start/ Child Care Center/Home
1.			☐					
2.			☐					
3.			☐					
4.			☐					
5.			☐					

Part 5. Total Household Gross Income. DO NOT COMPLETE PART 5 IF YOU LISTED A FIP OR FOOD ASSISTANCE NUMBER IN PART 3.
Report the gross income received by EACH household member one time in the correct column: weekly, every 2 weeks, twice a month or monthly. Gross income is the amount earned before taxes and other deductions, not take-home pay. Report all other monthly income received. Self- employed persons, see the worksheet on reverse side of this application.

List the names of everyone living in your household, including the children listed in Part 4. Attach a separate page if more space is needed. For FOSTER children, include only money available for child's personal use or child's own income.

Last Name	First Name	Age	Check if NO Income	Gross Income: Gross amount earned weekly	Gross Income: Gross amount earned every 2 weeks	Gross Income: Gross amount earned twice a month	Gross Income: Gross amount earned monthly	Other Monthly Payments or Income Received: Welfare, child support, alimony, adoption subsidies	Other Monthly Payments or Income Received: Pension, retirement, social security, SSI, VA benefits	Other Monthly Payments or Income Received: All other income
1.			☐							
2.			☐							
3.			☐							
4.			☐							
5.			☐							

Gross Income: Report income by how often the household member is paid.

Last four digits of my Social Security Number: **X XX - X X -** ____________ ☐ I do **not** have a Social Security Number.

If Part 5 is completed, the adult signing the form must provide the last 4 digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. **For further information refer to the Privacy Act Statement in the parent letter.**

Part 6. Certification and Signature. REQUIRED OF ALL APPLICANTS.

I certify (promise) that all information on this application is true and that all income is reported if required. I understand that I will receive benefits from Federal funds based on the information I give. I understand that officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal/milk benefits, and I may be prosecuted. Email of Adult Completing Form ________________________________

Signature of Adult Completing Form ______ Printed Name of Adult Completing Form ______ Date Signed ______

Address of Adult Completing Form ______ Town ______ ZIP Code ______ Work Phone ______ Home Phone ______ Cell Phone ______

Part 7. DO NOT WRITE BELOW THIS LINE. FOR ADMINISTRATIVE USE ONLY.

Income conversion factors for annual income: weekly X 52; two weeks X 26; twice a month X 24; monthly X 12

Household Income: $ ____________ ☐ Weekly ☐ Every 2 Weeks ☐ Twice Monthly ☐ Monthly ☐ Annually Household Size _____

Determining Official Signature ______ **Effective Date** ______

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hawk-i /Medicaid Information Form:
Read this information and sign if you do not want your name released to *hawk-i* or Medicaid.

If your children do not have health insurance, many families getting free and reduced price meals can also get free or low-cost health insurance for their children.

The law requires schools to share your free and reduced price meal eligibility information with Medicaid and *hawk-i*, the State's medical insurance program for children. Specifically, we will give them your child's name and your name and address. Medicaid and *hawk-i* can only use the information to identify children who may be eligible for free or low-cost health insurance and then to contact you. They are not allowed to use the information from your free and reduced meal application for any other purpose.

Childcare organizations may share this information at their option.

You are not required to allow us to share information from your children's free and reduced price meal application with Medicaid or the *hawk-i* program. It will not affect your children's eligibility for free and reduced price meals. If you do NOT want your information shared with Medicaid or *hawk-i*, you must tell us by completing the information below at the time you complete this eligibility application. If you want further information, you may call *hawk-i* at 1-800-257-8563.

I DO NOT want school/home sponsor/child care or Head Start center officials to share information from my free and reduced price meal application with Medicaid or *hawk-i*. Also, if you are already receiving Medicaid or *hawk-i*, please sign below. This will avoid another contact.

Name:	School/Child Care/Head Start Center:
Name:	School/Child Care/Head Start Center:
Name:	School/Child Care/Head Start Center:
Parent/Guardian Name (Printed) ________________________________ Signature_______________________________________ Date __________	

Self-Employment Income Worksheet: This worksheet will assist you in calculating the amount to report if you engage in farming, are self-employed, or have income from other sources.

Persons who are engaged in farming or who operate other types of private businesses may experience variations in cash flow or monthly income throughout the year. These persons may use their income tax records from the preceding calendar year as a basis for applying for the free and reduced price meals. The income to be reported is income derived from the business venture less operating costs incurred in the generation of that income. Deductions for personal expenses such as medical expenses and other non-business deductions are not allowed in reducing gross business income.

If you have additional income from other kinds of employment, this income must be treated as separate and apart from the income generated from your business venture. USDA **DOES NOT** recognize income the same way as IRS. USDA does not permit a loss from a business venture to off-set earnings from wages or salary. Though your business may have suffered a net operational loss, for purposes of this application, it is not possible to have a negative income. **The least self-employed income possible is zero (no income).** For example, if you operated a business at a net loss but held another job where you received wages, your income for purposes of applying for free or reduced price meals would be the income from your wages only. The loss from the business cannot be deducted from the amount of the income earned in the other job.

A prior year loss from farming or other private business operation cannot be used to reduce the current year net income for determining free and reduced price eligibility. Wages paid to a spouse or other family member in the operation of a farm or private business must be shown as household income in Part 5 of the application.

Income from private business operations is to be taken from your most recent U.S. Individual Income Tax Return - Form 1040. Use the lines from the 1040 that are identified.

Line 12 - Business income or (loss)	$
Line 13 - Capital gain or (loss)	$
Line 14 - Other gains or (losses)	$
Line 17 - Rental real estate, royalties, partnerships, S corporations, trusts, etc.	$
Line 18 - Farm income or (loss)	$
Total	$
The least income possible is zero (a negative number cannot be reported)	Total ÷12* =

*Enter amount in the "All Other Income Last Month" column in Part 5 on the front of the Iowa Eligibility Application.

Optional Waiver Information (for Schools only)

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Attached you will find a form that we are required to give all families. If you do not meet the income guidelines please feel free to fill in your child's name, write N/A across the form and then just sign on the signature line. If you have any questions, please contact Lindsay Wadsager at 563.323.5725.

This center participates in the Child and Adult Care Food Program (CACFP) administered by the United States Department of Agriculture (USDA). Participants are not charged separately for meals. However, by participating in this Program, the center receives partial reimbursement for nutritious meals served to children. The amount of reimbursement the center receives is determined by the information you provide. Providing information can help your center purchase nutritious food. Higher reimbursement will be given to the center for meals served to enrolled children from families whose income is at or below the level shown in the chart below. Please read the instructions on the back, complete, sign and return the attached income application as soon as possible. An application that does not contain all required information cannot be used by the center. If required information is missing, free or reduced-price meal benefits will be denied. Call your center if you need help with the form. The information reported on this form will be filed and treated as confidential.

A foster child who is the legal responsibility of a welfare agency or court may be certified as eligible for free meals regardless of your household income. See instructions on the back for more information.

If you do not qualify now to receive free or reduced price meals, you may apply for benefits at any time during the year. If you have a decrease in household income, have an increase in family size, or have enrolled children that become eligible for food assistance or FIP, you may fill out an application at that time.

Income Eligibility Guidelines for Reduced Price Meals
Effective 7-1-2017 to 6-30-2018

Household Size	Reduced Price Meals				
	Yearly	Monthly	Twice per Month	Every Two Weeks	Weekly
1	$22,311	$1,860	$930	$859	$430
2	$30,044	$2,504	$1,252	$1,156	$578
3	$37,777	$3,149	$1,575	$1,453	$727
4	$45,510	$3,793	$1,897	$1,751	$876
5	$53,243	$4,437	$2,219	$2,048	$1,024
6	$60,976	$5,082	$2,541	$2,346	$1,173
7	$68,709	$5,726	$2,863	$2,643	$1,322
8	$76,442	$6,371	$3,186	$2,94110	$1,471
For each additional family member add:	+ $7,733	+ $645	+ $323	+ $298	+ $149

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

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. The last four digits of the social security number of the adult household member who signs the application must be listed. The social security information is not required when you apply on behalf of a foster child or if you list a Food Assistance number, or Family Investment Program number, or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the CACFP. We may share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

USDA Nondiscrimination Statement

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.

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Instructions for Completing Iowa Eligibility Application
Complete both sides of an application for each household.

All applicants should complete Part 1. This application may be used to apply for benefits in school meals or milk programs, child care centers and home based care for children. Check all boxes that apply to your family. You may make copies of a completed application for each program in which your child participates.

FIP OR FOOD ASSISTANCE HOUSEHOLD MEMBER, including child(ren) in Head Start or Even Start, follow these instructions.

Part 3. List one FIP or Food Assistance **Case Number** per household in the area provided. **Use the Case Number listed in the DHS Notice of Decision**. Eligibility based on Head Start or Even Start is available only if your child is enrolled in Head Start and documentation from the Head Start agency is provided. **NOTE: Medicaid, Title XIX and EBT card numbers are not acceptable.**

Part 4. List the name, date of birth, grade (if applicable), name of school/Head Start/child care center attended for each child in your household. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of your child's ethnic and racial status if you do not complete this section.

Part 5. Skip this section.

Part 6. Read the certification and complete this section.

HOMELESS, MIGRANT OR RUNAWAY, follow these instructions.

Part 2. For children attending school, check if any child is Homeless, Migrant, or a Runaway and call your child's school.

Part 4. List the name, date of birth, grade (if applicable), name of school/Head Start/child care center attended for each child in your household. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of your child's ethnic and racial status if you do not complete this section.

Part 5. Skip this section.

Part 6. Read the certification and complete this section.

FOSTER CHILD IN HOUSEHOLD, follow these instructions. A foster child is a child who is living with a household but who remains the legal responsibility of the welfare agency or court. Foster children can be included as household members or included on a separate application.

Part 4. List the child's name, date of birth, grade (if applicable), name of school/Head Start/child care center attended. Check the box for foster child. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of your foster child's ethnic and racial status if you do not fill this section.

Part 5. Complete this section only if the foster child receives money for personal use or has other regular personal income. If the foster child has no income, check the box indicating no income. DO NOT include the stipend received by the foster family to provide care to the foster child.

Part 6. Read the certification and complete this section.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions for reporting income.

Part 4. List the name, date of birth, grade (if applicable), name of school/Head Start/child care center/home attended for each child in your household. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of each child's ethnic and racial status if you do not complete this section.

Part 5. Follow these instructions to report total household income from last month.

Name: List the last and first names of **each** person living in your household, related or not (such as grandparents, other relatives, or friends); include yourself and all children living with you. The household decides whether to include the foster child on their household application with non-foster children. Attach another sheet of paper if needed.

Age: List the age of each household member.

Check if No Income: Put a mark in the box if the household member **does not** have an income.

Gross Income last month and how it was received: Report the amount of income received in the appropriate Gross Income column (weekly, every 2 weeks, twice monthly, **or** monthly). List the **gross income** each person earned from work.
This is not the same as take-home pay. **Gross income is the amount earned before taxes and other deductions.** The amount should be listed on your pay stub, or your boss can tell you. If you have a household member for whom last month's income was higher or lower than usual, list that person's expected average income. If the household includes the foster child, they must report any personal income received by the foster child on the foster parent's household application.

Other Monthly Payments or Income: Money is reported in this section if it is regularly received. List the amount each person received last month from welfare, child support, alimony, adoption subsidies, pensions, retirement, Social Security, Supplemental Security Income (SSI), and Veteran's benefits (VA benefits). In the **All Other Income** column, include Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, cash withdrawn from savings, investments or trusts, interest and **ANY OTHER INCOME**. Use the Self-Employment Income Worksheet on the back of the application to calculate net income for self-owned businesses, farm, or rental income and report in the **All Other Income** column.

Do not report: Scholarships, educational benefits, lump sum payments, combat pay, Deployment Extension Incentive Pay (DEIP) or children's incidental income from occasional activities such as babysitting, shoveling snow, or cutting grass. If you are in the Military Housing Privatization Initiative or get combat pay do not include these allowances.

Social Security Number: If the application is being made on the basis of income, the adult signing the form must provide the last 4 digits of his or her Social Security number or mark the "I do not have a Social Security number" box. If you do not provide your Social Security information or mark the box, your application cannot be processed.

Part 6. Read the certification and complete this section.

SUBMIT COMPLETED REGSTRATION PACKET:

- **Email to CCPacket@scottcountyfamilyy.org or fax to Amanda Dang @ 563.323.1922 or drop off at any Scott County Family Y branch or YMCA Kids Club site or Camp Abe Lincoln**

2020 CAMP ABE LINCOLN REGISTRATION FORM:

Complete only if your child is attending Camp Abe Lincoln.

CAMPER'S NAME: ____

Is this your child's first time at Camp Abe Lincoln? ☐Yes ☐No If yes, most recent year: __________

If someone/somewhere referred you, who can we thank? __________________________

Does your camper have any cabin/group requests? ______________________________

Any learning behaviors we should know about? ☐Yes ☐No Special dietary needs? ☐Yes ☐No

DAY CAMPS:

KINDER CAMP (AGES 4-6)	TRADITIONAL DAY CAMP (AGES 4-12)		DAY HORSE CAMP (AGES 10-15)	
Y Member rate*: $119/wk Comm. rate: $149/wk	Y Member rate*: $199/wk Comm. rate: $229/wk		Y Member rate*: $299/wk Comm. rate: $329/wk	
☐ June 24 – 26	☐ June 8 -12 Peter & the Lost Boys	☐ July 13 – 17 Olympics	☐ June 8- 12	☐ July 13 - 17
☐ July 8 – 10		☐ July 20 - 24 Pirates	☐ June 15 – 19	☐ July 20 – 24
☐ July 22 - 24	☐ June 15 – 19 Pirates	☐ July 27 – 31 Wet & Wild	☐ June 22 - 26	☐ July 27 - 31
	☐ June 22 – 26 Survivor	☐ Aug 3 – 7 Ninja Warrior	☐ June 29 – July 3	☐ Aug 3 - 7
	☐ June 29 – July 3 Spies	☐ Aug 10 -14 Peter & the Lost Boys	☐ July 6 - 10	☐ Aug 17 - 21
	☐ July 6 – 10 Super Heros	☐ Aug 17 – 21 Bonus Week		

*Must have a household membership with a local YMCA to receive member rate.

OVERNIGHT CAMPS:

STARTER CAMP (AGES 6-8)	TRADITIONAL OVERNIGHT CAMP (AGES 4-12)		OVERNIGHT HORSE CAMP (AGES 10-12)	
Y Member rate*: $224/week Comm. rate: $274/week	Y Member rate*: $424/week Comm. rate: $474/week		Y Member rate*: $524/week Comm. rate: $574/week	
☐ June 21 - 23	☐ June 7 – 12	☐ July 12 - 17	☐ June 7 – 12	☐ July 12 - 17
☐ July 5 -7	☐ June 14 – 19	☐ July 19 - 24	☐ June 14 – 19	☐ July 19 - 24
☐ July 19 - 21	☐ June 21 – 26	☐ July 26 – 31	☐ June 21 – 26	☐ July 26 – 31
	☐ June 28 – July 3	☐ Aug 2 – 7	☐ June 28 – July 3	☐ Aug 2 – 7
	☐ July 5 – 10	☐ Aug 9 -14	☐ July 5 – 10	☐ Aug 9 -14

*Must have a household membership with a local YMCA to receive member rate.

LEADERSHIP CAMPS:

TWO WEEK CAMP (AGES 10-14)	TEEN CAMP (AGES 13-15)	LEADER IN TRAINING (AGES 16-17)
Y Member rate*: $774/week Comm. rate: $874/week	Y Member rate*: $624/week Comm. rate: $674/week	Y Member rate*: $274/week Comm. rate: $324/week
☐ June 14 - 26	☐ June 7 – 26	☐ June 7 - 26
☐ July 26 - Aug 7	☐ July 19 – Aug 7	

*Must have a household membership with a local YMCA to receive member rate.

CAMP SESSION(S) AMOUNT:	$
TRADING POST ACCOUNT(OVERNIGHT ONLY):	$
TRAIL RIDE (AGE 10+) - $25 EACH:	$
TAX DEDUCTIBLE DONATION TO HELP SEND KIDS TO CAMP	$
TOTAL BALANCE DUE:	**$**

Deposit for each week ($25-Day; $50-Overnight) is required to reserve your spot. Balance must be paid in full no later than 2 weeks prior to session start date. Registrations after April 1st require full payment. Fees are non-refundable and non-transferable.

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