בס"ד

(845) 295-3111 * Fax(845) 295-3113 * Office@Baiseinu.org

January 30, 2025

Dear Parents,

We are very happy to have your daughter join us at Baiseinu. We are looking forward to a very enjoyable and uplifting summer both ברוחניות & גשמיות .It is of utmost importance that you carefully read fully the enclosed information regarding registration, in order to avoid unnecessary aggravation. Please verify that all the information on your account including your daughter's grade and trip choice is correct. If you notice any discrepancies, please email mistakes to office@baiseinu.org or leave a message at 845-295-3111 ext100 right away.

EARLY BIRD: If your entire balance and all the necessary forms are returned by March 15, you may deduct $50 per camper per half summer from full fees. Checks for July may be postdated no later than June 15. Checks for August may be postdated no later than July 15. Only if ALL the above conditions are met, will you be eligible for the early bird rates. Any returned checks will automatically forfeit your early bird special rate.

DISCOUNT: If your entire balance and all the necessary forms are returned by May 15, you may deduct $25 per camper per half summer from full fees. **You may apply for either the Early Bird or Discount per camper, not both.**

TZNIUS FORM: Baiseinu's special flavor is due largely to our girls' pride in adhering so strongly to our guidelines. Please realize that your daughter's acceptance implies that there will be no compromises in these areas whatsoever. It is understood that lack of compliance is immediate grounds to be sent home.

MEDICAL FORM: Past experience has shown that it is difficult to have the doctor's form filled out during the pre-summer rush. Please attend to this matter as soon as possible. Health department regulations require that the parents must complete and sign both sides of the consent form. We must also have copies of your insurance cards. Please spare us from having to return incomplete forms. Doctor's office must sign camp issued medical form regardless of whether you include a print out from the doctors office. We cannot use last years information or insurance card. **Due to recent outbreaks of serious illnesses, Baiseinu can only accept campers and staff members who are fully up-to-date on their vaccinations.**

REFUND POLICY: Your full deposit is refundable till February 15. If you sent in a deposit for a full summer and then pull out for one trip after February 15,, your deposit for that half will not be applied to your balance and will not be refundable. If you cancel your registration after February 15, the full $600 deposit will be forfeited. After May 1, you are responsible for the entire balance. This is regardless of whether a replacement is found. Please take this into account and consider your decisions seriously.

PLEASE NOTE FORMS MAY NOT BE SENT VIA FAX.

We are confident that you will help this registration proceed smoothly.

Thank you,
Baiseinu Office Staff

בס"ד

Tznius Form

ברוכות הבאות בשם ה'

We are happy to welcome your daughter(s) to Camp Baiseinu where we aim to create a רוח of תורהand קדושה. Due to the caliber of our campers, a letter stating the basic rules of צניעות would be superfluous. However.אין מזרזין אלא למזורזין We will therefore list a few פרטים that constantly need חיזוק.

1) Baiseinu t-shirts will be worn by campers' grade 7-9. **All tops may not be tight fitting**. Please note that a girl who is typically a small size often has to purchase a larger size so that it fits properly. Words printed across the T-shirt or **sweatshirt** does not befit a בת ישראל. We recommend that all weekday tops have a collar.

2) Skirts: In order to compliment the צורה of a בת ישראל, skirts should be mid-calf length. We have a zero-tolerance policy towards skirts that are very long. Denim material or the denim look is not in line with the Baiseinu standards. **As such we have eliminated Chambray skirts as an option for a Baiseinu camper**. Most slinky straight skirts even when lined, present a major breach in צניעות, primarily in that it clings to the legs. Please steer away from the straighter look. More material will equal more mobility and ultimately is more צניעות'דיג.

3) Hair longer than shoulder length should be pulled back in a ponytail at all times (including Shabbos). Keep in mind that hair accessories must be of a refined nature.

4) Pantyhose: A) Only tights may be worn. **Socks is an infringement of our basic camp rules.**
B) Concerning natural color pantyhose, all Halachic Authorities agree that it must be recognizable from a distance that the leg is covered. As always Baiseinu girls strive for the best. We have therefore compiled a listing of acceptable natural color pantyhose for those times that you choose to wear this color:

- Memoi 60 Denier
- Florence 60 Denier
- Filaaze 60 Denier

5) Bathrobes should be zippered or buttoned. Please bring a swimming T-shirt(bathing suit fabric). Tights or **long socks** must be worn to the pool.

6) Please bring along only **full-length nightgowns** with long sleeves**. Pajamas/night shirts/pj sets, are NOT ACCEPTABLE.**

7) Only kosher Sansa clip or Mp3 will be allowed in camp. Please make sure that only **refined Heimeshe music** is sent to camp. Music from your private device is for personal use only and may not be played publicly in the bunkhouse. We reserve the right for all music devices to be screened by staff members. Any device with video or internet capabilities is not allowed. J-pods or any other game device cannot be brought to camp. Please take this seriously so that we don't encounter uncomfortable situations.

8) No camper may have a cell phone in camp.

9) Cameras: As per the advice of our Rabbanim, we do not wi-fi in our camp. In order to prevent questionable pictures/video to be shared, **new memory card should be brought to camp**.

Please note: by accepting your slot in camp you are thereby committed to abide by the above rules.

We hope that with your full cooperation your daughter's camp experience will be refreshing and enjoyable, filled with growth in all aspects of עבודת השם. צניעות is the trademark of Camp Baiseinu. We thank you for assistance in upholding these standards.

Important Medical & Health Notices

MENINGOCOCCAL MENINGITIS IMMUNIZATION

New York State Public Health Law (NYS PHL) §2167 requires us to distribute information about meningococcal disease and vaccination to all campers. This law became effective on August 15, 2003.

Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.

Cases of meningitis among teens and young adults 15 to 24 years of age (the age of most college students) have more than doubled since 1991. The disease strikes about 3,000 Americans each year and claims about 300 lives. Between I 00 and 125 meningitis cases occur on college campuses and as man y as 15 students will die from the disease.

A vaccine is available that protects against four types of the bacteria that cause meningitis in the United States - types A, C, Y and W-135. These types account for nearly two thirds of meningitis cases among college students.

To learn more about meningitis and the vaccine, please consult your child's physician. You can also find information about the disease at New York State Department of Health Website: www.health.state.ny.us, or website of the Centers for Disease Control and Prevention (CDC): www.cdc.govincidodidbmdidisease.info

Due to recent outbreaks of serious illnesses, Baiseinu can only accept campers and staff members who are fully up-to-date on their vaccinations.

IMPORTANT NOTICE: The camp office MUST be notified if your child is exposed to any communicable disease during the three weeks prior to camp attendance.

If your child has a chronic or acute medical condition, it is imperative that the camp be notified. To speak to the camp nurse regarding confidential medical information regarding your child, please call our office to be directed to the EMT. All information will be held confidential.

Parental Consent Form

TO BE COMPLETED BY PARENTS

Date of Birth_____ **CAMPER'S NAME**_____

Present Age_____ **HOME ADDRESS**_____

CITY_____ **STATE**_____ **ZIP**_____

Summer Phone # _____ **Home Phone #** _____

Name of Bungalow Colony _____ **Father's Business #** _____

In Emergency Call: Name_____ **Mother's Business #** _____

Phone #_____ **Cell Phone #** _____

MEDICAL & PRESCRIPTION DRUG INSURANCE

Enclose copies of your Medical Insurance card & prescription drug coverage (if separate). If no cards are attached, you will be billed at regular drug store rates for all drugs, and you will be responsible for any additional medical costs.

Insurance Information

Company Name_____ **Policy In The Name Of**_____ **Relationship**_____

Group Name and Number_____ **Identification Number**_____

Other/Secondary Insurance Carrier & I.D. If Different From Above _____

Please detail any special circumstances or conditions that our medical or counseling staff should be aware of that will assist us in the care of your child (e.g. frequent colds, headaches, stomach aches, diarrhea, constipation, vomiting, bed-wetting, sensitivity to insect bites, homesickness, nightmares, anxiety reactions, etc.) and what you recommend as treatment:

_____

_____

DEPARTMENT OF HEALTH REGULATIONS REQUIRES THE FOLLOWING AUTHORIZATIONS FOR CHILDREN ATTENDING A SLEEP-AWAY CAMP:

PARENTS' AUTHORIZATION

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted by me and the examining physician.

I hereby give permission to the physician selected by the camp director to order X-rays, routine tests and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above.

Parent's Signature_____ **Date**_____

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR TEMPORARILY SEPARATED FROM PARENTS

I /we, the undersigned, custodial parent(s)/guardian(s) of _____, a minor, do hereby authorize Camp Baiseinu, and/or Rabbi Chaim Luria, as our agent(s) to act in my/our name, place and stead in any way in which I/we could do, if I/we were personally present, with respect to said minor, including without limitation, giving consent to any diagnostic procedure or medical care which is deemed advisable by, and is to be rendered under the general or special supervision of, any licensed physician or surgeon on the staff of or engaged by Catskill Regional Medical Center whether such diagnosis or treatment is rendered at the office of said physician or at Catskill Regional Medical Center. It is understood that this authorization is given in advance of any specific need for treatment but is given to provide authority on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the physician in the exercise of his best judgment may deem advisable. This authorization shall remain effective until August 31, 2025, unless sooner revoked in writing delivered to said agent(s).

Parent's Signature_____ **Date**_____

MENINGOCOCCAL MENINGITIS IMMUNIZATION

My child has (I have):

☐ had the meningococcal meningitis immunization (Menomune™) within the past 10 years.
Date received: _____[Note: The vaccine's protection lasts for approximately 3 to 5 years. Revaccination may be considered within 3-5 years.]

☐ read, or have had explained to me, the information regarding meningococcal meningitis disease. My child (I) will obtain immunization against meningococcal meningitis within 30 days from my private health care provider.

☐ read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child (I) will not obtain immunization against meningococcal meningitis disease.

Parent's Signature_____ **Date**_____

TRIP/ACTIVITY AUTHORIZATION

I hereby authorize Camp Baiseinu to take my child off camp grounds on trips organized as part of the program. This may include swimming and/or boating. My child may participate in any activity organized by Baiseinu, including but not limited to land sports, waterfront activities, indoor activities, bicycling, hiking, cook-outs etc. and I assume the inherent risk of such camp activities and camp programs. I will hold the camp harmless in the event of injury or property damage or loss as a result of such activities. I waive any and all rights to make a claim in case of injury or damage.

Parent's Signature_____ **Date**_____

Medical / Immunization Form

Camper's Name _____ **Weight** _____

Home Address _____ **City** _____ **State** ____ **Zip** ____ **Height** _____

Individualized Orders

Standard Over-the-Counter/PRN Medications (available in the infirmary/First Aid Kit) To be administered at the discretion of an RN unless otherwise indicated by you

DRUG (or generic equivalent)	**ROUTE**	**DOSAGE**	**SCHEDULE**	**CONTRA-INDICATED** Check only if Med. Is NOT to be given	**COMMENTS**
Tylenol	PO	Per label instructions by age/weight	q 6hr prn for discomfort or elevated temp		
Ibuprofen	PO	Per label instructions by age/weight	q 4hr prn for discomfort or elevated temp		
Robitussin	PO	Per label instructions by age/weight	q 4hr prn for cough		
PeptoBismol	PO	Per label instructions by age/weight	q 30 min to 1hr prn for diarrhea (not>8 doses /24hr)		
Mylanta	PO	Per label instructions by age/weight	TID-QID prn for gastric upset		
Dramamine	PO	Per label instructions by age/weight	½ hr before embarkation, then q 6-8hr pm for motion sickness		
Dimetapp	PO	Per label instructions by age/weight	q 6-8hr for nasal congestion/ drainage		
Benadryl	PO	Per label instructions by age/weight	q 6hr prn for allergic reaction		
Sudafed	PO	Per label instructions by age/weight	g 6-8hr for nasal congestion/ drainage		
Tums	PO	Per label instructions by age/weight	q 30 min prn for gastric upset/ heartburn		
NaphconA	Eye gtts	Per label instructions by age/weight	1-2gtts affected eye for itching/ burning		
Milk of Magnesia	PO	Per label instructions by age/weight	BID-TID pm for gastric upset/ constipation		
Ear Drops	TOP	Per label instructions by age/weight	As indicated		
Cortisone Ointment	TOP	Per label instructions by age/weight	As indicated		
Antifungal Ointment Spray	TOP	Per label instructions by age/weight	As indicated		

SPECIAL RESTRICTIONS:

Diet_____
Swimming_____
Strenuous Activity_____
Other_____

To the best of my knowledge the information stated above is true and accurate and it is my opinion that the camper listed above is physically able to engage in all camp activities, except as noted above.

Physician's Signature_____ **Date**_____

Physician's Name_____ **Phone**_____

Immunization History:

Please record month and year of basic immunizations and most recent booster. We do not have it on file from previous years.

Immunization	Date Basic Series Completed	Most Recent Booster
DPT or DT		
TETANUS		
ORAL POLIO		
MMR		
PPD/MANTOUX		
HEPATITIS A		
HEPATITIS B		
VARICELLA		

Allergies	✔	Comments
PENICILLIN		
SULFA		
CEPHALOSPORINS		
Other Medication		
Food Allergies List foods child is allergic to		
Bees/Insect Bites		

Has child ever had an anaphylactic reaction? ❒Yes
If yes, are you must send an EpiPen to avoid charges.
(Check expiration date)

Medical History

Indicate Date of Illness

Chicken Pox _____
Measles _____
German Measles _____
Mumps _____
Hepatitis _____
Pneumonia _____

Indicate if being treated for the following:

Diabetes __ Seizures __
Seasonal Allergy __ Rheumatic Fever __
Frequent Ear Infection __ Frequent Strep Throat __
Asthma __ (If child is being treated for asthma please send along the tubing for the nebulizer as well as all inhalers being used.) Make sure nurse is notified before camp begins.

❒Positive PPD Date _____ CXRay Date _____

List Dates & Desc. of Operations, Serious Injuries, Etc.

_____
_____
_____
_____

Chronic or Recurrent Illness & Suggested Treatment

_____
_____
_____
_____

Due to recent outbreaks of serious illnesses, Baiseinu can only accept campers & staff members who are fully up-to-date on their vaccinations.

Date Withdrew_____ F _____ R _____ D_____

2024-2025 Application for Free and Reduced Price School Meals/Milk

To apply for free and reduced price meals for your children, read the instructions on the back, complete **only one** form for your household, sign your name and **return it to the address listed below.** Call ***(phone number),*** if you need help. Additional names may be listed on a separate paper.

Return Completed Applications to: **Baiseinu**
661 Dahill Road
Brooklyn NY 11218

1. List all children in your household who attend school:

Student Name	School	Grade/Teacher	Foster Child	Homeless Migrant, Runaway
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

2. SNAP/TANF/FDPIR Benefits:
If anyone in your household receives either SNAP, TANF or FDPIR benefits, list their name and CASE # here. **Skip to Part 4 and sign the application.**

Name: _____ CASE #: _____

3. Report all income for ALL Household Members (Skip this step if you completed step 2)

All Household Members (including yourself and all children that have income).
List all Household members not listed in Step 1 (including yourself) **even if they do not receive income**. For each Household Member listed, if they do receive income, report total income for each source in whole dollars only. If they do not receive income from any other source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of household member	Earnings from work before deductions ***Amount / How Often***	Child Support, Alimony ***Amount / How Often***	Pensions, Retirement Payments ***Amount / How Often***	Other Income, Social Security ***Amount / How Often***	No Income
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐

Total Household Members (Children and Adults) ☐☐

***Last Four Digits of Social Security Number:** XXX-XX-__ __ __ __ I do not have a SS# ☐

*When completing section 3, an adult household member must provide the last four digits of their Social Security Number (SS#) or mark the "I do not have a SS# box" before the application can be approved.

4. Signature: An adult household member must sign this application before it can be approved.
I certify (promise) that all the information on this application is true and that all income is reported. I understand that the information is being given so the school will get federal funds; the school officials may verify the information and if I purposely give false information, I may be prosecuted under applicable State and federal laws, and my children may lose meal benefits.
Signature: _____ **Date:** _____
Email Address: _____
Home Phone: _____ Work Phone: _____ Home Address: _____

5. Ethnicity and Race are optional; responding to this section does not affect your children's eligibility for free or reduced price meals.

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino
Race (Check one or more): ☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Island ☐White

DO NOT WRITE BELOW THIS LINE – FOR SCHOOL USE ONLY

Annual Income Conversion (Only convert when multiple income frequencies are reported on application)
Weekly X 52; Every Two Weeks (bi-weekly) X 26; Twice Per Month X 24; Monthly X 12

☐ SNAP/TANF/Foster
☐ Income Household: Total Household Income/How Often: _____/_____ Household Size: _____
☐ Free Meals ☐ Reduced Price Meals ☐ Denied/Paid
Signature of Reviewing Official_____ **Date Notice Sent:** _____

APPLICATION INSTRUCTIONS

To apply for free and reduced price meals, complete only one application for your household using the instructions below. Sign the application and return the application to _____. If you have a foster child in your household, you may include them on your application. A separate application is not needed. Call the school if you need help: _____. Ensure that all information is provided. Failure to do so may result in denial of benefits for your child or unnecessary delay in approving your application.

PART 1 ALL HOUSEHOLDS MUST COMPLETE STUDENT INFORMATION. DO NOT FILL OUT MORE THAN ONE APPLICATION FOR YOUR HOUSEHOLD.

(1) Print the names of the children, including foster children, for whom you are applying on one application.
(2) List their grade and school.
(3) Check the box to indicate a foster child living in your household, or if you believe any child meets the description for homeless, migrant, runaway (a school staff will confirm this eligibility).

PART 2 HOUSEHOLDS GETTING SNAP, TANF OR FDPIR SHOULD COMPLETE PART 2 AND SIGN PART 4.

(1) List a current SNAP, TANF or FDPIR (Food Distribution Program on Indian Reservations) case number of anyone living in your household. The case number is provided on your benefit letter.
(2) An adult household member must sign the application in PART 4. SKIP PART 3. Do not list names of household members or income if you list a SNAP case number, TANF or FDPIR number.

PART 3 ALL OTHER HOUSEHOLDS MUST COMPLETE THESE PARTS AND ALL OF PART 4.

(1) Write the names of everyone in your household, whether or not they get income. Include yourself, the children you are applying for, all other children, your spouse, grandparents, and other related and unrelated people in your household. Use another piece of paper if you need more space.
(2) Write the amount of current income each household member receives, before taxes or anything else is taken out, and indicate where it came from, such as earnings, welfare, pensions and other income. If the current income was more or less than usual, write that person's usual income. Specify how often this income amount is received: weekly, every other week (bi-weekly), 2 x per month, monthly. If no income, check the box. The value of any child care provided or arranged, or any amount received as payment for such child care or reimbursement for costs incurred for such care under the Child Care and Development Block Grant, TANF and At Risk Child Care Programs should not be considered as income for this program.
(3) Enter the total number of household members in the box provided. This number should include all adults and children in the household and should reflect the members listed in PART 1 and PART 3.
(4) The application must include the last four digits only of the social security number of the adult who signs PART 4 if Part 3 is completed. If the adult does not have a social security number, check the box. If you listed a SNAP, TANF or FDPIR number, a social security number is not needed.
(5) An adult household member must sign the application in PART 4.

OTHER BENEFITS: Your child may be eligible for benefits such as Medicaid or Children's Health Insurance Program (CHIP). To determine if your child is eligible, program officials need information from your free and reduced price meal application. Your written consent is required before any information may be released. Please refer to the attached parent Disclosure Letter and Consent Statement for information about other benefits.

USE OF INFORMATION STATEMENT

Use of Information Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not submit all needed information, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the primary wage earner or other adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child 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 lunch and breakfast programs.
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.

DISCRIMINATION COMPLAINTS

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.

FREE AND REDUCED PRICE MEAL APPLICATION FACT SHEET

When filling out the application form, please pay careful attention to these helpful hints.

SNAP/TANF/FDPIR case number: This must be the complete valid case number supplied to you by the agency including all numbers and letters, for example, E123456, or whatever combination is used in your county. Refer to a letter you received from your local Department of Social Services for your case number or contact them for your number.

Foster Child: A child who is living with a family but who is under the legal care of the welfare agency or court may be listed on your family application. List the child's "personal use" income. This includes only those funds provided by the agency which are identified for the personal use of the child, such as personal spending allowances, money received by his/her family, or from a job. Funds provided for housing, food and care, medical, and therapeutic needs are not considered income to the foster child. Write "0" if the child has no personal use income.

Household: A group of related or non-related people who are living in one house and share income and expenses.

Adult Family Members: All related and non-related people who are 21 years of age and older living in your house.

Financially Independent: A person is financially independent and a separate economic unit/household when his or her earnings and expenses are not shared by the family/household. Separate economic units in the same residence are characterized by prorating expenses and by economic independence from one another.

Current Gross Income: Money earned or received at the present time by each member of your household before deductions. Examples of deductions are federal tax, State tax, and Social Security deductions. If you have more than one job, you must list the income from all jobs. If you receive income from more than one source (wage, alimony, child support, etc.), you must list the income from all sources. Only farmers, self-employed workers, migrant workers, and other seasonal employees may use their income for the past 12 months reported from their 1040 Tax Forms.

Examples of gross income are:

- Wages, salaries, tips, commissions, or income from self-employment
- Net farm income – gross sales minus expenses only – not losses
- Pensions, annuities, or other retirement income including Social Security retirement benefits
- Unemployment compensation
- Welfare payments (does not include value of SNAP)
- Public Assistance payments
- Adoption assistance
- Supplemental Security Income (SSI) or Social Security Survivor's Benefits
- Alimony or child support payments
- Disability benefits, including workman's compensation
- Veteran's subsistence benefits
- Interest or dividend income
- Cash withdrawn from savings, investments, trusts, and other resources which would be available to pay for a child's meals
- Other cash income

Income Exclusions: The value of any child care provided or arranged, or any amount received as payment for such child care or reimbursement for costs incurred for such care under the Child Care Development (Block Grant) Fund should not be considered as income for this program.

If you have any questions or need help in filling out the application form, please contact:

Name: _____ Title: _____

Telephone Number: _____