Thank you for choosing "Camp by the Bay!" Camp begins on Monday, July 1, 2024. To ensure your child's start date the Highlighted items must be submitted by June 17, 2024.

Your Child: _____

OFFICE USE ONLY

Student's ID #: _____

Start Date: _____

End Date: _____

Staff initials: _____

- ☐ Birth Certificate.
- ☐ Parent's photo identification.
- ☐ Current Physical Forms.
- ☐ Up to date Immunization records.
- ☐ Community Child Care Solutions Contract.
  - ☐ Pending ☐ Approved
- ☐ Private
- ☐ First payment of $175.00 or $200.00
- ☐ Registration fee of $25.00
- ☐ Food Form

If you have any questions or concerns, contact,

732.638.2820/malicea@prahd.org (school age)

732.638.2818/mjuarez@prahd.org (Pre-k)

Thank you for choosing Camp by the Bay!

We are looking forward to having an Awesome and Adventurous Summer!

The Puerto Rican Association for Human Development, INC. (PRAHD)
100 First St. Perth Amboy, NJ 08861
Phone: (732) 638-2820 (school age) (732) 638-2818 (Pre-K)

	AGE GROUP
	Preschool (3-5 yrs. old)
	School- Age (6-13 yrs. old

	PROGRAMS	
	$75.00	Before and after care (weekly)
	$175.00	Summer Camp (weekly) 8:00am-4:00pm
	$250.00	Extended Care (weekly) 7:30am-5:30 pm
	Staff use signature	

STUDENT'S NAME: _____

Start Date: _____/_____/_____ **End Date:** _____/_____/_____

Gender: ☐Female ☐Male **DOB:** __/__/__ **Age:** _____

Address_____ **City:** _____ **State:** _NJ___ **Zip Code:** _____

Language: ☐ Spanish ☐English ☐Other: _____

PARENT / GUARDIAN INFORMATION

Mother/ Guardian's name: _____ **Phone No.** (____) _____-_____

Email Address: _____

Address: _____ **City:** _____ **State:** _____

Employer's Name: _____ **Phone no.** (____) _____-_____

Father/ Guardian's name: _____ **Phone No.** (____) _____-_____

Email Address: _____ **Address:** _____ **City:** _____ **State:** ___
Employer's Name: _____ **Phone no.** (____) _____-_____

Who is the Legal Guardian: ☐Mother ☐ Father ☐ Both Parents ☐ Grandparents ☐ Other _____

*If parents share custody or obtain full custody of child, please attach court papers to this application.

Race: ☐ Hispanic ☐ Caucasian ☐ Native American ☐ African American ☐ Asian ☐Other _____

Household income: ☐ 10,000-20,000 ☐ 20,000-30,000 ☐ 30,000-40,000 ☐ 40,000-50,000 ☐ 50,001

Student's Name: _____ Date of Birth: ___/___/___

HOME INFORMATION

Using the space below, please write the names of all household members.

	Name	Date of Birth	Relationship to student
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Please write all the languages spoken at home: _____

In which language would you prefer to receive information? _____

ADDITIONAL INFORMATION:

Race: ☐ Hispanic ☐White ☐ Native American ☐ African American ☐ Asian ☐Other: _____

Ethnic Group: ☐ Dominican☐Puerto Rican ☐ Peruvian ☐ Colombian ☐ Mexican ☐ Other: _____

Household Income: ☐ 10,000-20,000 ☐ 20,000-30,000 ☐ 30,000-40,000 ☐ 40,000-50,000 ☐ 50,000+

HEALTH VERIFICATION/EMERGENCY TREATMENT

Does your child have health insurance? ☐ YES ☐ NO

Policy Name:_____ Provider: _____

Policy Number:_____

Pediatric: _____ Pediatrics' Phone Number (___)__-_____

Address:_____

Does your child have a health condition that limits him/her from [participating in any activities? _____

Does your child take any medication? ☐ YES ☐ NO

Please be very specific and answer all the questions. If a question does not apply to you write not applicable.

List all the medications that your child takes:	
List all health concerns and/or allergies (environmental and/or food):	
List behavioral concerns and or special care required:	

Please make sure everything is filled out. If your child suffers from a medical condition and or has allergies it is very important you notify us immediately.

Parent/guardian signature:_____ Date:___/___/___

Revised 2023

Student's Name: _____ Date of Birth: ___/___/___

PHOTO RELEASE:

☐ I give PRAHD permission to photograph my child and to use pictures/videos of my child in school newsletters, local paper, social media, websites, and brochures.

☐ I DO NOT give PRAHD permission to photograph my child and to use pictures/videos of my child in school newsletters, local paper, social media, websites, and brochures.

Parent/guardian signature:_____ Date:___/___/___

ACTIVITY AUTHORIZATION

I hereby give consent for my child to participate in all local scheduled trips such as neighborhood walks, local parks and other local locations. If a special trip is planned in need of transportation, I understand a separate permission slip with my signature is required.

Parent/guardian signature:_____ Date:___/___/___

EMERGENCY CONTACTS:

In my absence, I hereby give authorization to the following individuals to pick up and or contact in case of an emergency. I understand they must show a photo ID verifying their name when they pick up and be over the age of 18 years old. I also understand that if there is a change of information it is my responsibility to notify PRAHD immediately.

1. Name:_____ Relationship to child: _____

   Address: _____ Phone number (___) ___-_____

2. Name:_____ Relationship to child: _____

   Address: _____ Phone number (___) ___-_____

3. Name:_____ Relationship to child: _____

   Address: _____ Phone number (___) ___-_____

4. Name:_____ Relationship to child: _____

   Address: _____ Phone number (___) ___-_____

5. Name:_____ Relationship to child: _____

   Address: _____ Phone number (___) ___-_____

I certify that all the information in this application is correct.

Parent/guardian signature:_____ Date:___/___/___

Camp By The Bay
100 First Street * Perth Amboy, NJ 08861
Phone: (732) 638-2880 Fax: (732) 826-3082

IMPORTANT

Please fill out attached food form and return

If you receive food stamps only fill out Option 1a and the adult household member signature portion. Nothing else.

Or

If you do not receive food stamps fill out ALL of Option 3, please include all your monthly income. (Add only immediate family members, those members that parents support financially) and the adult household member signature section.

If you need help, please call to make an appointment.

Thank you!

IMPORTANTE

Favor de reliene el formulario de alimentos adjunto y devuélvalo mañana

Si recibe cupones de alimentos solo complete la Opción 1a y la parte donde dice firma de miembro adulto del hogar. Nada más.

O

Si no recibe cupones de alimentos, complete TODA la Opción 3, incluya todos sus ingresos mensuales. (Agregue solo a los miembros de la familia inmediata, aquellos miembros que los padres apoyan financieramente) y la parte de la firma del miembro adulto del hogar (donde dice Adult household members debajo de la sección amarilla).

Si necesita ayuda, llame para hacer una cita. ¡Gracias!

2024 NEW JERSEY CHILD AND ADULT CARE FOOD PROGRAM ELIGIBILITY APPLICATION

NAME(S) & AGE(S) OF ENROLLED PARTICIPANT _____ (Name) _____ (Age); _____ (Name) _____ (Age)

OPTIONAL: RACIAL/ETHNIC IDENTITY OF PARTICIPANT

Check one ETHNIC identity:

[ ] Hispanic or Latino [ ] Not Hispanic or Latino

Mark one or more RACIAL identity (ies):

[ ] American Indian or Alaska Native [ ] Asian [ ] Black or African American

[ ] Native Hawaiian or Other Pacific Islander [ ] White

Enrollment Information

Check (✓) each day the above participant is enrolled for care, the hours of care each day, and the meal type(s) served:

DAYS OF CARE: ☐MON ☐TUES ☐WED ☐THURS ☐FRI ☐SAT ☐SUN

HOURS OF CARE:
Swing / Rotating Shifts: (If Applicable)

MEAL TYPES SERVED: ☐*BREAKFAST* ☐*A.M. SUPPLEMENT* ☐ *LUNCH* ☐*P.M. SUPPLEMENT* ☐*DINNER*

CHILD DAY CARE FOOD PROGRAM PARTICIPANTS ONLY

OPTION 1A: BENEFICIARIES of Supplemental Nutrition Assistance Program (SNAP) *(formerly Food Stamps)*, Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR)

If you are now receiving SNAP,TANF or FDPIR for this child, complete one of the following numbers:

SNAP CASE #_____ *OR* TANF CASE #_____ *OR* FDPIR CASE #_____

OPTION 1B: FOSTER CHILD

If you are applying for a foster child, check the box and list any personal income which has been identified by specific category such as clothing, school fees, allowances, etc.:

FOSTER CHILD ☐ INCOME $_____

ADULT DAY CARE FOOD PROGRAM PARTICIPANTS ONLY

OPTION 2: BENEFICIARIES of SNAP, FDPIR, SSI or Medicaid

If you are now receiving SNAP, SSI, FDPIR or Medicaid complete one of the following numbers:

SNAP #_____ *OR* FDPIR CASE #_____ *OR* SSI CASE # _____ *OR* MEDICAID CASE #_____

OPTION 3: HOUSEHOLD ELIGIBILITY - COMPLETE IF YOU DID NOT COMPLETE OPTION 1A, OPTION 1B, OR OPTION 2

Complete the following information: Household Members, Social Security Numbers and Income.

NAMES OF ALL OTHER HOUSEHOLD MEMBERS: (*Related and Unrelated*)	MONTHLY INCOME *(Complete One Or More - Before Deductions)*				
	MONTHLY (Gross Earnings) WAGES / SALARY	MONTHLY SOCIAL SECURITY PENSIONS RETIREMENT	MONTHLY UNEMPLOYMENT WORKMEN'S COMPENSATION	MONTHLY WELFARE CHILD SUPPORT ALIMONY	MONTHLY ANY OTHER INCOME
1.	$	$	$	$	$
2.	$	$	$	$	$
3.	$	$	$	$	$
4.	$	$	$	$	$
5.	$	$	$	$	$
6.	$	$	$	$	$
7.	$	$	$	$	$
8.	$	$	$	$	$
9.	$	$	$	$	$
10.	$	$	$	$	$
TOTAL NUMBER IN HOUSEHOLD *(INCLUDE ENROLLED PARTICIPANT)*: _____					
TOTAL GROSS HOUSEHOLD INCOME:				$ _____	

ADULT HOUSEHOLD MEMBER SIGNATURE and LAST FOUR DIGITS of SOCIAL SECURITY NUMBER: *(See Privacy Act Statement below)*
An Adult Household Member must sign and date this form, and list the last four (4) digits of his or her Social Security Number.
If you do not have a social security number, mark the box (☒) - "I do not have a Social Security Number".

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that the Food Stamp, TANF, SSI, or Medicaid Number of the enrolled participant is correct, or that all income is reported. I understand that this information is being given for the receipt of Federal funds issued to the day care center based on the information I provide. I understand that CACFP officials may verify this information; and that deliberate misrepresentation may result in the participant losing meal benefits, and I may be prosecuted under the applicable State and Federal laws. *An Adult Household Member must complete the following:*

Signature: _____ Address: _____

Print name: City: _____ State: _____ Zip Code:

Date: _____ Phone Number: _____

Last four (4) digits of Social Security Number: * * * - * * * - _____ ☐ I do not have a Social Security Number

PRIVACY ACT STATEMENT: The National School Lunch Act requires that, unless the participants' Case Number is provided, you must include the Social Security Number of the adult household member signing the application or indicate that the household member does not have a Social Security Number. Provision of a Social Security Number is not mandatory, but if a Social Security Number is not given or an indication is not made that the signer does not have such a number, the participant cannot be determined eligible for free or reduced priced menus. The Social Security Numbers may be used to identify you for verifying the correctness of information stated on the application. These verifications may include audits, investigations and may include contacting employers to determine income, contacting a Food Stamp or TANF office to determine current certification for receipt of Food Stamps or TANF benefits, contacting the State Employment Security office to determine the amount of benefits received and checking the documentation produced by household members to verify the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims or legal actions if incorrect information is reported. These acts must be told to all household members whose Social Security Numbers are reported on this form.

TO BE COMPLETED BY DAY CARE AGENCY ONLY - DO NOT WRITE BELOW THIS LINE

Determination: Free _____ Reduced _____ Paid _____

Signature of Determining Official: _____ Date_____

TOTAL MONTHLY INCOME $_____

Conversion factors to figure monthly income: Weekly x 4.33
Twice a month x 2
Every 2 weeks x 2.15