Youth Alternatives of Oil City, Inc.
Youth Alternatives Children's Camping Program
1 Graff Street, Oil City, PA 16301, (814) 676-5785
1250 Elk St. Franklin, PA 16323, (814) 346-0188

2019

This year's week-long summer camp for income eligible children, ages 8- 15 years old, from Venango and Forest Counties will be July 28th – August 3rd, 2019.

Again, we will be at the Beaumont Scout Reservation in Ashtabula County, Ohio. Campers will be housed according to sex and age, in group cabins staffed around the clock.

Camp staff includes Volunteer Leaders who have a long-time experience in running the camp programs, Youth Alternatives Employees, Lifeguards, and Nurses. We are committed to providing the campers with competent and highly qualified supervision.

We have made registration as easy as possible; an application has been sent with this letter. All you need to do is fill it out and send it back to the address at the top of this page.

*** There MUST be separate registration forms for EACH camper; If you need additional forms, you may make copies.**

*** BOTH forms of the registration application MUST be filled out COMPLETELY; The emergency phone number you include needs be someone who can be reached during the day. Also, be sure it includes ALL available information about allergies, special medical needs, and medications. Please include a copy of your child's insurance card.**

*** The Ohio Summer Food Service Program Eligibility form must be COMPLETED. Your child's individual case number needs to be on the form. This is Part 1 of the form. It is a 10-12 digit number. This number is needed for us to accept your child's application. (this is not the number on your food stamp card, its your county case number I need)**

*** Return your registration forms as soon as possible; There are a limited number of spaces available, and campers will be chosen on a first come, first serve basis.**

To insure the safety of our campers and to provide a quality program to the widest range of eligible children possible, YACC reserves the right to reject any applicant, or to send a child home from camp. This includes children who are infected with lice or other contagious conditions.

If you have any questions or concerns call (814) 676-5785 Ext.105 or (814) 346-0188, Monday – Friday, 10am-6pm. If you get the answering machine, leave your name, number, and reason for your call. One of our staff will return your call as soon as possible.

If your camp registration is accepted, you will be notified by mail. Your letter will provide the information on where to catch the camp buses, camp policies, and what your child should bring to camp. * It could take 2 – 5 weeks to hear back from us. Please be patient.

If your camp registration is not accepted, you will be notified by phone and/or mail.
Hope to see you on July 28th.

All forms must be filled out completely.

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REGISTRATION INFORMATION; Personal information about your child.

Name: _____ **Male:** _____ **Female:** _____

Address: _____ **Age:** _____

City / State / Zip: _____

SS#: _____ **Date of Birth:** _____

PA Access Card # (if applicable):
_____
***Include a photocopy of your child's PA DPW Access Card.**

Has your child been away from home overnight? Yes No
Is your child free from lice and other contagious conditions? Yes No
***Any child with lice and other contagious conditions may be sent home from camp at the discretion of camp staff.**

PARENT/GUARDIAN INFORMATION
Name: _____ **SS#:** _____
Address: _____ **Phone:** _____
City / State / Zip: _____

EMERGENCY INFORMATION
Contact Name: _____ **Daytime Phone:** _____
Relationship: _____ **Evening Phone:** _____

MEDICAL INFORMATION; Attach an extra sheet if necessary.
Medication / Dosages: _____
Known Medical Problems or Special Needs:
_____
Allergies: _____ **Date of Last Tetanus Shot:**
_____

INSURANCE INFORMATION
Insurance Company Name: _____
Policy #: _____ **Effective Date:** _____
Address: _____

PHOTO RELEASE
I hereby consent to and authorize the use and reproduction by Youth Alternatives of Oil City, Inc., of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/ my ward for promotional printed materials, educational activities, and exhibitions or for any other use for the benefit of the program.

Date:_____ **Signature:**_____

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AGREEMENT

_____ **(Child's Name) has my permission to participate in all camp activities and have his/her picture or name use on behalf of Youth Alternatives Children's Camping Program. I am the legal parent/guardian of the above-mentioned child: I understand there is certain assumption of risk inherent in camping related activities. I agree to hold free and harmless Youth Alternatives Children's Camping Program, its agents, servants, officers, directors, and volunteers from any and all legal and financial liability for any injury my child may suffer at camp. In the event of an emergency, I authorize medical treatment by physician(s), hospital personnel, and emergency medical personnel, and I assume responsibility of all costs not covered by an insurance policy or third-party payer. In the event of Youth Alternatives Children's Camp needing additional information, I authorize access to my child's school and medical records by representative of Youth Alternatives Children's Camping Program.**

Signature: _____ **Date:** _____

It is my understanding that my child will be sent home from camp because of any of the following actions, (profanity towards other children and/or staff, fighting with other campers and/or staff, inappropriate behavior towards other campers and/or staff). It is my understanding that if my child is sent home for inappropriate behaviors, I will assume responsibility for reimbursement of $240.00 for the camp fee, which Youth Alternatives provides for the child. It is my understanding that I will also be responsible for picking up my child immediately from camp if he or she is sent home early. This form must be signed in order for your child to participate in our camp.

Signature:_____ **Date:**_____

All applications must be returned by July 19th, 2019.

It is Youth Alternatives of Oil City, Inc. policy to afford equal opportunity to all individuals regardless of race, color, religion, sex, national origin, or age, and to conform to applicable laws and regulations.

FY 2019-20 **Youth Alternatives, Inc.**

Please indicate interests of the youth being enrolled:

Referring Agency/Program:

One Graff Street, Oil City, PA 16301 **1250 Elk St, Franklin, PA 16323**
814- 676-5785 Fax: 814- 677-0697 **814-346-0188**
Email: kids.rule@yavenangocounty.org Executive Director, Corrina Woods

REGISTRATION AND RELEASE FORM

REGISTRATION
Name of Youth being enrolled: _____

Youth's Birth Date: _____ Youth's Social Security Number: _____

Has the above youth ever been put in placement through CYS, JPO (please circle if yes), or indicate other?
_____

Parents/Guardians _____
(First & Last Names of ALL Parents/Guardians in Household)

Street_____ City_____ State_____

Zip Code_____Home Phone_____ Other Phone_____

In case of emergency contact_____ Phone_____

Or contact_____ Phone_____

Number of YOUTH in Household: _____

Number of Adults in Household: _____

LIABILITY RELEASE
Above youth may be participating in Youth Alternatives programs. I acknowledge the risks and potential risks of some Youth Alternative's programs. However, I feel that the possible benefits to me/my son/my daughter ward are greater than the risks assumed. I hereby am intending to be legally bond for myself, my heirs and assigns, executor or administrators, waive and release forever all claims for damages against Youth Alternatives of Oil City, Inc., its board of directors, instructors, therapists, aides, volunteers and/or employees for any and all injuries and/or losses I, my son/my daughter/my ward may sustain while participating in the Youth Alternative program.

Date:_____ Signature:_____
(youth if 18 yrs. old, parent, or guardian)

PHOTO REALEASE
I hereby consent to and authorize the use and reproduction by Youth Alternatives of Oil City, Inc., of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities, and exhibitions or for any other use for the benefit of the program.

Date:_____ Signature:_____
(youth if 18 yrs. old, parent or guardian)

YOUTH ALTERNATIVES, INC.

1 Graff Street, Oil City, PA 16301 **1250 Elk St, Franklin, PA 16323**
814-676-5785 Fax: 814-677-0697 **814-346-0188**

Email: kids.rule@yavenangocounty.org Executive Director: Corrina J. Woods

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event that emergency aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Youth Alternatives of Oil City, Inc. to:

1. Secure and retain medical treatment and transportation if needed,
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Name of Enrolled Youth: _____ Phone: _____

Address: _____

In the event that I can not be reached, Contact: _____ Phone: _____
or Contact: _____ Phone: _____

Physician's Name: _____ Phone: _____

Preferred Medical Facility: _____

Health Insurance Co.: _____ Policy #: _____

CONSENT PLAN
This authorization includes x-ray, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person listed below is unable to be reached.

Consent Signature: _____ Date: _____
(Youth if 18 yrs. Old or Parent or Guardian)

NON-CONSENT PLAN
I do not give my consent for emergency medical aid/treatment in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event that emergency aid/treatment is required, I wish the following procedures to take place:

Non-Consent Signature: _____ Date: _____

Print Name of Person Signing Form: _____

Phone: _____

Additional Health/Medical Comments (if Needed):

Ohio Summer Food Service Program-2019 Income Eligibility Application Attachment 10

INSTRUCTIONS: *Part 1* of this form is to be used only for children receiving OWF, Ohio Works First (was formerly TANF and AFDC) or for children living in a household receiving Food Stamp benefits. *Part 2* is only for children not receiving Food Stamp benefits or OWF benefits. Fill in the part which addresses your situation. An Adult signature is needed when completing both Part1 or 2. If you need more space, use a separate piece of paper. (* Asterisk items must be filled in for each part you complete.)

*** PRINT CHILD INFORMATION WHEN COMPLETING EITHER PART 1 OR PART 2:** Enter **ONLY** name of those children who will be participating in the Summer Food Service Program.

* NAME	AGE	* NAME	AGE
1.		3.	
2.		4.	

PART 1 - FOR CHILDREN RECEIVING SNAP (FOOD STAMPS) OR OHIO WORKS FIRST (OWF)

_____YES, I received SNAP (Food Stamp) or OWF benefits for the child(ren) listed above this month and request meal benefits. My Food Stamp or OWF number is:

_____ * SNAP (FOOD STAMP NUMBER) (10-12 digit number) **OR**

_____ *OHIO WORKS FIRST NUMBER OR

_____ * FDPIR Identification Number (Food Distribution Program on Indian Reservations)

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that the food stamp and OWF numbers are correctly reported. I understand that this information is being given for receipt of federal funds; that program officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

_____ *

SIGNATURE OF ADULT HOUSEHOLD MEMBER ADDRESS DAYTIME PHONE DATE

***PART 2 - FOR CHILDREN NOT RECEIVING SNAP OR OWF* BENEFITS**

HOUSEHOLD MEMBERS AND MONTHLY INCOME: List the names of everyone living in your household including yourself, all related and non-related individuals and children. Include children listed above. List all income received last month on the same line with the person who received it. List each amount under the correct title. You must list gross income **BEFORE** deductions, taxes, or social security, etc. To figure monthly income, if income is received: every week, multiply the total gross income x 4.33; every two weeks, multiply the total gross income x 2.15; twice a month, multiply the total gross income x 2; or once a year, divide the total gross income by 12.

*** HOUSEHOLD MEMBERS**	*** INCOME BY SOURCE**			
LIST ALL HOUSEHOLD MEMBERS' NAMES (LAST NAME, FIRST NAME)	MONTHLY EARNINGS FROM WORK BEFORE DEDUCTIONS	MONTHLY WELFARE, CHILD SUPPORT,	MONTHLY PENSIONS, RETIREMENT, SOCIAL SECURITY	ALL OTHER MONTHLY INCOME
1.				
2.				
3.				
4.				
5.				
6.				

FOSTER CHILD: Complete a separate application for each foster child. In certain cases, meals served to foster children may be reimbursed regardless of the foster family's income. If you are applying for foster children living with you, complete the application as if for a family of one. List the child's name and monthly personal use income or enter "0" if the child has no personal use income. An adult signature is needed. Personal Use Income $_____

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for receipt of federal funds; that program officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

LAST 4 DIGITS OF SOCIAL SECURITY #_____

*** SIGNATURE** OF ADULT HOUSEHOLD MEMBER *** SOCIAL SECURITY NUMBER** OF ADULT HOUSEHOLD MEMBER (Write "None" if adult signer does not have a SSN)

HOME ADDRESS ZIP CODE DAYTIME PHONE DATE

Total Household Monthly Income **FOR SPONSOR USE ONLY** **Signature of Authorized Official** **Date**

$_____ELIGIBILITY DETERMINATION **_____APPROVED_____DENIED** _____

Ohio Summer Food Service Program For Children Income Eligibility Application For Camps and Enrolled Sites

Dear Parent or Guardian:

Our organization serves nutritious free meals as part of the federally funded Summer Food Service Program for Children (SFSP). Children are defined by the SFSP as being 18 years of age and under or persons over 18 who are determined by a state or local public educational agency to be mentally or physically disability. In order to be eligible for the SFSP, we must document the number of enrolled children with household incomes less than or equal to the SFSP family size/income guidelines. With your cooperation, we can qualify for federal reimbursement and keep costs to you at a minimum. Please complete and return this form.

RACIAL/ETHNIC CATEGORY: You are not required to answer this question. If you choose, please check one or more of the following racial or ethnic identities.

_____American Indian or Alaskan Native Asian Black or African American

____Native Hawaiian or other Pacific Islander _____White _____Hispanic or Latino_____Not Hispanic or Latino

NON-DISCRIMINATION: The U. S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital information or employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Complaint Form, found online at http://wwwascr.usda.gov/complaint_filing_cust.html, or at any USDA office or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410, by fax (202) 690-7442 or e-mail at program.intake@usda.gov, (individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339:or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

REDUCED INCOME ELIGIBILITY GUIDELINES – 185% Guidelines

to be effective from July 1, 2015 through June 30, 2016

Households with incomes less than or equal to the reduced price values below are eligible for free or reduced-price meal benefits.

HOUSEHOLD SIZE	YEAR	MONTH	TWICE PER MONTH	EVERY TWO WEEKS	WEEK
1	21,775	1,815	908	838	419
2	29,471	2,456	1,228	1,134	567
3	37,167	3,098	1,549	1,430	715
4	44,863	3,739	1,870	1,726	863
5	52,559	4,380	2,190	2,022	1,011
6	60,255	5,022	2,511	2,318	1,159
7	67,951	5,663	2,832	2,614	1,307
8	75,647	6,304	3,152	2,910	1,455
For each additional family member, add	7,696	642	321	296	148

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Privacy Act Statement: Section 9 of the National School Lunch Act (NSLA) requires that, unless your child's food stamp or OWF 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 application cannot be approved. This notice must be brought to the attention of the household member whose social security number is disclosed. The social security number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the application or shared with other persons directly connected with the administration or enforcement of the program under the NSLA or Child Nutrition Act of 1966 to determine program eligibility. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a food stamp or welfare office to determine current certification for receipt of food stamps or OWF benefits, contacting the state employment security office to determine the amount of benefits received and checking the documentation produced by household members to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims or legal action if incorrect information is reported.

FORM REV 1/16