CHILD APPLICATION

SUMMER 2018

PROGRAM DATES: JUNE 25th - AUGUST 3rd, MONDAY-FRIDAY

ABOUT RAY OF HOPE

Ray of Hope Summer Day Program is a six-week program for children ages 5-12 (must have completed Kindergarten) with emotional, behavioral, and/or economic challenges. It is a day program unlike any other offering arts and crafts, recreation, field trips, and artistic enrichment. Ray of Hope strives to introduce empowering social skills and inspiring life principles through story and relationship. Ray of Hope is for the kids who most need, yet seldom experience, such a holistic, well staffed, and fun summer.

CHILD APPLICATION DEADLINE: May 11th, 2018

Office Use Only
Date Application Received By:

Rebound
CONNECTING | EMPOWERING | RESTORING

316 E. McLeod Rd, Suite 102
Bellingham, WA 98226
Phone: 360-714-0700
Fax: 360-714-0704

APPLICATION INFORMATION SUMMER PROGRAM 2018

Ray of Hope 2018 Details Where: Happy Valley Elementary School

1041 24th St, Bellingham, WA 98225

When: June 25th – August 3rd, Monday – Friday 9am – 3pm (Extended Care Available)

Cost: $1,200 per child for entire summer (Includes $50 registration)

Ray of Hope is a licensed childcare provider pursuant to WAC 170-290-0125, eligible for childcare assistance benefits; childcare provider number is 920531.

A Day at Ray of Hope

Morning Session: The morning starts with breakfast where announcements are made and super green badges are awarded. Children and leaders are then dismissed for small group time. During small group time, campers explore social skills and life skills including positive choices, expressing feelings, peer pressure, and caring for one another. Kids explore the themes of excellence, empowerment, self-control, teamwork, kindness, and hope. After small group time, campers participate in artistic and recreational activities with lunch following.

Afternoon Activities: In the afternoon, groups participate in either a field trip in Whatcom County, enrichment activities led by community members, or swim time at Lake Samish. These activities are opportunities for kids to build positive relationships in a fun and creative context. The day ends with "Highlights", where all campers celebrate moments of camp spirit. The kids then transition into their respective pick up and transportation groups to get home after a full day at camp.

Application Directions

1. Complete the following application information by filling appropriate answer spaces and by marking check boxes.

2. Review each section of the application to ensure your application is 100% complete.

3. Return your completed application to Rebound of Whatcom County using one of the following methods:
    - By Mail or Drop Off: 316 E. McLeod Rd Suite 102 Bellingham WA 98226
    - By Fax: 360-714-0704

RAY OF HOPE CHILD APPLICATION CHECKLIST:

There are a limited number of spots available at Ray of Hope each summer. Due to recent staff changes, we are only able to accept a maximum of 80 kids this summer. The successful completion of your child's application will ensure that it will be processed in a timely fashion. If any part of the Ray of Hope child application is not filled in, we will consider the application incomplete and may affect your child's opportunity to attend Ray of Hope. Please take a moment and review this checklist to ensure you have completely filled out ALL sections of the application and attached the appropriate documents.

If you have more than one child that you are applying for, please complete an application for EACH child, we are not able to transfer information from one application to another, even if the information is the same.

RAY OF HOPE PAYMENT OPTIONS (Page 4)

- Select appropriate payment option.
- If necessary, attach any documents as requested to your child(ren)'s application.
- If applicable, we need a copy of your most current DSHS or Working Connections award letter.
- If applying for a partial scholarship, please do NOT turn in your child application without attaching the scholarship application to it. Your application will be considered incomplete if you check the scholarship application option without attaching it.

CHILD REGISTRATION (Page 5)

- Double check that every box and line is filled in, write "N/A" if a particular section does not apply.

EMOTIONAL/BEHAVIORAL HISTORY (Page 6-7)

- To best serve your child, please fill in this section with as much information as possible so we can provide a safe and successful summer for your child.
- Include a copy of your child's IEP or any behavior plan they are currently on at school. Your application will be considered incomplete if it is not attached and may affect your child's chances of getting in.

MEDICAL INFORMATION (Page 8)

- Fill out complete information about your child's medical history and needs.
- Sign and date at the bottom

RELEASE OF CONFIDENTIAL INFORMATION (Page 9)

- Please fill this form out completely. It may contain information you have already provided however we need it on this form also.
- Sign and date at the bottom

ADDITIONAL RAY OF HOPE SERVICES (Page 10)

Transportation

- Please only request transportation services if you are unable to transport your child to and/or from Ray of Hope each day. We have limited transportation routes. Please indicate Yes or No on the application.

Extended Care

- Please indicate Yes or No on the application. Your child ***CAN NOT*** have both transportation and extended care.

DECLARATION, INCOME STATEMENT, IMMUNIZATION RECORDS (Page 10-12)

- Be sure and sign and date this portion so we know who has completed the application and how best to reach you.
- Please completely fill out the confidential income statement, we are required by the state to have a form for every child. Your application will be considered incomplete if we don't receive this.
- Immunization form – **we need every child's immunization records filled out on this specific form**, we cannot accept other forms from medical providers or schools.

RAY OF HOPE TUITION PAYMENT OPTIONS

Child's Name: _____

Parent/Guardian's Name: _____

The total cost of tuition for Ray of Hope is $1200 per child for the summer, which includes a $50 registration fee. Please select one of the following payment options. If options 1-3 do not apply, choose option 4 or 5.

☐ Option 1: WASHINGTON STATE CHILDCARE BENEFITS (Working Connections Child Care or Seasonal Child Care)

If the child's parent/guardian's income qualifies AND one of the following is true, you MAY be able to receive childcare benefits from Washington state that can be designated to pay for most of the child's tuition at Ray of Hope:

- Works outside the home or is self-employed,
- Attends school or job training,
- Is part of "Working Connections" or "Work First"
- Is a seasonal agriculture worker,
- Has a child with special needs.
- Is homeless, lives in transitional housing, or lives temporarily with family or friends

☐ I am approved for Washington State childcare benefits (Attach a copy of your award letter with this application)
- Client Identification Number (Not TANF number) _____

☐ I want to find out if I qualify for Washington State Childcare Benefits.
- Apply immediately by calling 1-877-501-2233 or going online at www.washingtonconnection.org.

☐ Option 2: DIVISION OF CHILD AND FAMILY SERVICES (DCFS or CPS)

If the child is in state-appointed care, they MAY qualify for childcare assistance benefits to apply to Ray of Hope tuition through the Division of Child and Family Services (DCFS) or Child Protective Services (CPS). Contact your DCFS/CPS caseworker to verify before submitting this application. You will need to tell them Ray of Hope's state provider number is 1066259. Once verified, complete the following:

_____ _____

Name of Social Worker Date of Verification

☐ Option 3: DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

If the child has a developmental disability (physical or intellectual delays, including autism spectrum), they MAY qualify for tuition reimbursement from the Developmental Disabilities Administration (DDA). To see if you qualify, contact the local DDA office at 360-714-5000.

☐ My child has already been approved for DDA benefits (Attach a copy of your approval document with this application)

☐ Option 4: I WILL COVER TUITION IN FULL.
- We offer flexible payment plans and payment schedules. We will contact you to set up a payment agreement.

☐ Option 5: I WOULD LIKE TO APPLY FOR A PARTIAL SCHOLARSHIP.
- We accept a limited number of Ray of Hope students on partial scholarship. All partial scholarships are available on a first come, first serve basis (with some exceptions). Scholarship applicants will need to complete an additional scholarship application and provide income verification as requested. Please request a scholarship application by calling or emailing Shelli Wood at 360-714-0700 x4 or shelli@reboundfamilies.org and one will be sent to you. Please DO NOT turn in your application without attaching the scholarship application.

CHILD REGISTRATION (PLEASE PRINT)

Child's Name: _____
First Name Last Name

Child's Birthdate: _____ Child's Gender (select): ◯ Male ◯ Female
Month/Day/Year

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name (Adult Living with Child): _____

Relationship to child (select): ◯ Parent ◯ Foster Parent ◯ Relative/Other (specify): _____
(Grandparent, Aunt, Friend, etc.)

Phone Number: _____ Alternative Phone Number: _____ Verified #'s _____

Email address (include only if checked regularly): _____

Address: _____
Street City/State/ZIP

CHILD INFORMATION

Past Rebound of Whatcom County Programs Attended:

Ray of Hope _____ Year(s) Roots _____ Year(s) Other Rebound program _____ Year(s) None _____

Does child/family have a case worker through any of the following agencies? ◯ Yes ◯ No

- ☐ DCFS (Division of Child and Family Services)
- ☐ DSHS (Department of Social and Health Services)
- ☐ Lummi Children's Services
- ☐ CCS (Catholic Community Services)
- ☐ Opportunity Council
- ☐ Other: _____

Case Worker Name: _____ Phone #: _____

Agency: _____ Email Address: _____

Ethnicity (check at least one):

- ☐ Asian
- ☐ White/Non-Hispanic
- ☐ Other: _____
- ☐ Black/African-American
- ☐ Hispanic
- ☐ American Indian/Alaskan Native
- ☐ Native Hawaiian/Pacific Islander

Please list any of the child's ongoing physical conditions: _____

School(s) Attended September 2017 - June 2018: _____

School Attending Fall 2018: _____ Grade Fall 2018: At _____

school, does child currently have (circle): ☐ IEP Behavior Plan ☐ One-on-One Aide ☐ 504 Plan

EMOTIONAL & BEHAVIORAL HISTORY (pg.1)

CHILD NAME: _____

Accurate information in the following section greatly impacts a child's success at Ray of Hope. It is vital in helping staff better serve the children during the program. Please be as accurate as possible.

1. What are some positive factors that are an important part of this child's life? (check all that apply)

- ☐ Caring School Environment
- ☐ Positive Adult Role Models
- ☐ Supportive Family Members
- ☐ Healthy Friendships with Peers
- ☐ Desire to Help Others
- ☐ Safe Home Environment
- ☐ Creativity
- ☐ Enjoyment of Learning
- ☐ Good Self Esteem
- ☐ Avoiding Unhealthy Peer Pressure
- ☐ Achievement in School
- ☐ Sense of Humor
- ☐ Involvement in a Faith Community
- ☐ Important Sibling Relationships
- ☐ Hope for their Personal Future
- ☐ Other(s): _____

2. What are some of this child's strengths and interests?

_____

_____

_____

3. What things have helped this child overcome difficult situations?

_____

_____

_____

4. Has this child ever demonstrated any of the following behaviors? (check all that apply)

- ☐ Physical Aggression (Hitting, kicking, biting, etc.)
- ☐ Verbal Aggression (Swearing, threatening, shouting, etc.)
- ☐ Difficulty sitting still/paying attention
- ☐ Difficulty with change/transitions
- ☐ Low Self-Esteem
- ☐ Withdrawn
- ☐ Defiance
- ☐ Bullying
- ☐ Running Away
- ☐ Tantrums
- ☐ Lying
- ☐ Stealing
- ☐ Eating Disorder
- ☐ Sexual Acting Out
- ☐ Toileting Accidents

5. What are some challenging behaviors that this child shows currently (within the last 3 months)?

_____

_____

_____

6. What types of situations have led to behavioral escalations from this child?

_____

_____

_____

EMOTIONAL & BEHAVIORAL HISTORY (pg.2)

7. Please indicate to the best of your knowledge all of the following that apply:

My Child:

- ☐ Takes medication
- ☐ Has been hospitalized (emotional, behavioral, and/or psychiatric reasons)
- ☐ Has been in foster care
- ☐ Is currently in foster care
- ☐ Has witnessed abuse
- ☐ Has been a victim of abuse
- ☐ Has been exposed to drug/alcohol abuse
- ☐ Has a family member in prison
- ☐ Lives with a family member with mental illness

Within the Last Year:

- ☐ Has lost a family member (death, divorce/breakup, prison, moved away)
- ☐ Has gained a family member (new baby, marriage/partnership, adoption)
- ☐ Has changed caregivers
- ☐ Has experienced housing instability (homelessness, shelter, transitional housing, etc.)
- ☐ Other: _____

8. What experiences has your child had that could be important to their Ray of Hope experience?

_____

_____

_____

9. Please indicate to the best of your knowledge all of the following that apply:

Has Been Diagnosed With:

- ☐ ADD/ADHD
- ☐ Anxiety Disorder
- ☐ Autism/Asperger's Syndrome
- ☐ Developmental Delay
- ☐ Learning Disability
- ☐ Oppositional Defiant Disorder
- ☐ Sensory Integration Disorder
- ☐ Other: _____

Has Current*:

**Include any plans with your application.*

- ☐ IEP
- ☐ 504 Plan
- ☐ Behavior plan
- ☐ One on One aid in School

Has Been/Is Involved With:

- ☐ An In-Home Intervention Program (e.g. SWIFT, CHAPS, etc.)
- ☐ School Behavior Program (e.g. Bridges, Discovery school, etc.)
- ☐ Mental Health Counseling
- ☐ Juvenile Detention
- ☐ Other: _____

Please provide any important details about any of the above checked boxes:

_____

_____

_____

Please Note: Ray of Hope may request that parents or guardians pursue someone who has worked closely with this child to complete an additional Emotional Behavioral Form (Such as a Teacher, Counselor, School Administrator, Social Worker, or Mentor). Providing this additional information helps staff better serve children during the Ray of Hope program.

MEDICAL INFORMATION

CHILD NAME: _____

1. Medical History (Required):

* Doctor's name: _____ Phone: _____ Last Physical Exam (mm/yy): _____
* Dentist's name: _____ Phone: _____ Last Dental Exam (mm/yy): _____
* Does your child have any allergies? (medicine, food, hay fever, insect bites, etc.): ◯ Yes ◯ No

  Please list: _____
* Does your child have any illnesses, disabilities or injuries? (physical or mental.): ◯ Yes ◯ No

  Please list: _____
* Is there a specific camp activity you do NOT want your child to participate in? ◯ Yes ◯ No

  Please state which activity/why: _____

2. Over-the-Counter Medication:

I hereby give Ray of Hope camp staff permission to administer the following products according to manufacturer's instructions. I trust Ray of Hope camp staff to use their best judgment as situations arise, and, if in doubt, he/she can call for verification.

☐ YES to all items A – O ☐ NO to all items A - O

☐ A. Sunblock	☐ F Lip Balm	☐ K. Cough Syrup
☐ B. Tylenol	☐ G. Antiseptic Ointment	☐ L. Cough Drops
☐ C. Ibuprofen	☐ H. Hydrogen Peroxide	☐ M. Decongestant
☐ D. Band-aids	☐ I. Rubbing Alcohol	☐ N. Antihistamine
☐ E. Insect Repellant	☐ J. Anti-Itch Cream	☐ O. Ipecac Syrup

3. Prescription Medication:

* Does your child currently take any prescription medications? (**list all below**) Will ◯ Yes ◯ No
* Ray of Hope need to administer any prescription medications? (If yes, a doctor's letter is required. Please include with application.) ◯ N/A ◯ Yes ◯ No

Prescription Medication:	Diagnosis for Medication:	Administered at Ray of Hope	Administered at Home
_____	_____	☐	☐
_____	_____	☐	☐
_____	_____	☐	☐
_____	_____	☐	☐

4. Medical Release:

My child has permission to engage in all prescribed program activities, except as noted above. The undersigned do hereby authorize the directors of Ray of Hope camp or such substitute as they may designate as agent for the undersigned to consent to an X-Ray examination, anesthetic, medical, dental or surgical diagnosis or treatment and hospital care for the Minor which is deemed advisable by and to be rendered under the general or special supervision of any physician and surgeon, licensed under the provision of the Medical Practice Act or any dentist licensed under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, or hospital, camp or elsewhere. This authorization remains effective while the above said Minor is en route to and from or involved or participating in any camp program, unless revoked in writing by the undersigned and delivered to the Ray of Hope program director.

_____ _____

Signature Date

RELEASE OF CONFIDENTIAL INFORMATION

Child's Name:_____ Date of Birth: _____
Month/Day/Year

If there is any educational information, physical or mental healthcare information, or case information that you want a professional to share with Ray of Hope administrators, please list their contact information in the following areas.

I authorize the exchange of information described below between Rebound of Whatcom County and the following agency(s) and/or individual(s):

□ School Personnel, Name (Teacher, Counselor, Administrator, etc.): _____

School Name: _____

Contact Phone and Email: _____

□ Healthcare Provider, Name (Doctor, psychologist, therapist, etc.): _____

Healthcare Organization Name: _____

Contact Phone and Email: _____

□ Agency Caseworker(s), Name(s) (DCFS, CCS, DSHS, etc.): _____

Agency(s):_____

Contact Phone and Email: _____

□ Additional Parent/Legal Guardian, Name: _____

Contact Phone and Email: _____

□ Other Contact, Name: _____

Contact Phone and Email: _____

This authorization applies to the following circumstances (check all that apply):

☐ Educational Data/IEP ☐ Social/Developmental ☐ Psychological ☐ Medical ☐ Other: _____

Restrictions: Providers who receive this information may not release it to someone else unless another authorization form is signed.

Parent/Guardian Signature:_____ Date:_____

Relationship to child: _____

Expiration: This authorization is valid from date signed until August 3, 2018 (conclusion of Ray of Hope Program).

ADDITIONAL RAY OF HOPE SERVICES

Transportation

Ray of Hope is able to transport a limited number of students to and from the program site.

- Pick-ups and drop-offs will occur at locations central to the families using transportation.
- Pick-ups will generally occur between 8:00 and 8:45 AM. Drop-offs will generally occur between 3:05 and 3:45 PM.

I would like to apply for Ray of Hope Transportation for my child. Please Check: ☐ Yes ☐ No

Extended Care

For parents who are unable to transport their children for Ray of Hope at 9:00 AM and 3:00 PM, and are unable to utilize Ray of Hope transportation, extended care is available for a limited number of students.

- Morning extended care begins at 8:30 AM. Afternoon extended care ends at 5:30 PM.

I would like to apply for Ray of Hope extended care my child. Please Check: ☐ Yes ☐ No

If you have requested additional services, Rebound will contact you for further information.

DECLARATION

Please review the complete Ray of Hope 2018 child application. By signing below, I certify that I have completed this application thoroughly, honestly, and to the best of my ability.

I also certify that I am the legal guardian of the child specified, or have been granted authority by the legal guardian or the state of Washington to complete this application on his/her behalf.

This Application Was Completed By:

Name:_____ Signature:_____ Date: _____

Relationship to Child:_____ Phone:_____ Email: _____

All follow up questions/correspondence from Rebound regarding this application should be directed to (select):

☐ Child's Legal Guardian ☐ Child's Social Worker ☐ Other:_____ _____

Name Phone

AFTER COMPLETING & RETURNING APPLICATION:

1. Expect a call from a staff person at Rebound of Whatcom County to notify you if your application is incomplete.

2. Following the final completion of this application, you will receive a letter notifying you of your child's placement status into the Ray of Hope program. Thank you.

Certificate of Immunization Status (CIS)

For Kindergarten-12th Grade / Child Care Entry

Office Use Only:	
Reviewed by:	Date:
Signed Cert. of Exemption on file? ❑ Yes ❑ No	

Please print. See back for instructions on how to fill out this form or get it printed from the Washington Immunization Information System.

Child's Last Name: **First Name:** **Middle Initial:** **Birthdate** (MM/DD/YY)**:** **Sex:**

I give permission to my child's school to share immunization information with the Immunization Information System to help the school maintain my child's school record.

Parent/Guardian Signature Required **Date**

I certify that the information provided on this form is correct and verifiable.

Parent/Guardian Signature Required **Date**

♦ Required for School and Child Care/Preschool
● Required Only for Child Care/Preschool

	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY
Required Vaccines for School or Child Care Entry						
♦ **DTaP / DT** (Diphtheria, Tetanus, Pertussis)						
♦ **Tdap** (Tetanus, Diphtheria, Pertussis)						
♦ **Td** (Tetanus, Diphtheria)						
♦ **Hepatitis B** ❑ 2-dose schedule used between ages 11-15						
● **Hib** (*Haemophilus influenzae* type b)						
♦ **IPV / OPV** (Polio)						
♦ **MMR** (Measles, Mumps, Rubella)						
● **PCV / PPSV** (Pneumococcal)						
♦ **Varicella** (Chickenpox) ❑ History of disease verified by IIS						
Recommended Vaccines (Not Required for School or Child Care Entry)						
Flu (Influenza)						
Hepatitis A						
HPV (Human Papillomavirus)						
MCV / MPSV (Meningococcal)						
MenB (Meningococcal)						
Rotavirus						

Documentation of Disease Immunity

Healthcare provider use only

If the child named in this CIS has a history of Varicella (Chickenpox) or can show immunity by blood test (titer) it MUST be verified by a healthcare provider

I certify that the child named on this CIS has:

❑ a verified history of Varicella (Chickenpox).

❑ laboratory evidence of immunity (titer) to disease(s) marked below. **Lab report(s) for titers MUST also be attached.**

❑ Diphtheria	❑ Mumps	❑ Other:
❑ Hepatitis A	❑ Polio	_____
❑ Hepatitis B	❑ Rubella	_____
❑ Hib	❑ Tetanus	
❑ Measles	❑ Varicella	

Licensed healthcare provider signature (MD, DO, ND, PA, ARNP) Date

Printed Name

Instructions for completing the Certificate of Immunization Status (CIS): printing it from the Immunization Information System (IIS) or filling it in by hand.

To print with immunization information filled in: Ask if your healthcare provider's office enters immunizations into the WA Immunization Information System (Washington's statewide database). If they do, ask them to print the CIS from the IIS and your child's immunization information will fill in automatically. You can also print a CIS at home by signing up and logging into MyIR at https://wa.myir.net. **If your provider doesn't use the IIS, email or call the Department of Health to get a copy of your child's CIS: waiisrecords@doh.wa.gov or 1-866-397-0337.**

To fill out the form by hand:

#1 Print your child's name, birthdate, sex, and sign your name where indicated on page one.

#2 Vaccine information: Write the date of each vaccine dose received in the date columns (as MM/DD/YY). If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guides below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as **DTaP**, Hepatitis B as **Hep B**, and Polio as **IPV**.

#3 History of Varicella Disease: If your child had chickenpox (varicella) disease and not the vaccine, **a health care provider must verify chickenpox disease to meet school requirements**.

- ❑ If your healthcare provider can verify that your child had chickenpox, ask your provider to check the box in the Documentation of Disease Immunity section and sign the form.
- ❑ If school staff access the IIS and see verification that your child had chickenpox, they will check the box under Varicella in the vaccines section.

#4 Documentation of Disease Immunity: If your child can show positive immunity by blood test (titer) and has not had the vaccine, have your healthcare provider check the boxes for the appropriate disease in the Documentation of Disease Immunity box, and sign and date the form. **You must provide lab reports with this CIS**.

Reference guide for vaccine abbreviations in alphabetical order For updated list, visit https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf

Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A	Hepatitis A	MCV / MCV4	Meningococcal Conjugate Vaccine	OPV	Oral Poliovirus Vaccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hep B	Hepatitis B	MenB	Meningococcal B	PCV / PCV7 / PCV13	Pneumococcal Conjugate Vaccine	VAR / VZV	Varicella
DTP	Diphtheria, Tetanus, Pertussis	Hib	*Haemophilus influenzae* type b	MPSV / MPSV4	Meningococcal Polysaccharide Vaccine	PPSV / PPV23	Pneumococcal Polysaccharide Vaccine		
Flu (IIV)	Influenza	HPV (2vHPV / 4vHPV / 9vHPV)	Human Papillomavirus	MMR	Measles, Mumps, Rubella	Rota (RV1 / RV5)	Rotavirus		
HBIG	Hepatitis B Immune Globulin	IPV	Inactivated Poliovirus Vaccine	MMRV	Measles, Mumps, Rubella with Varicella	Td	Tetanus, Diphtheria		

Reference guide for vaccine trade names in alphabetical order For updated list, visit https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB®	Hib	Fluarix®	Flu	Havrix®	Hep A	Menveo®	Meningococcal	Rotarix®	Rotavirus (RV1)
Adacel®	Tdap	Flucelvax®	Flu	Hiberix®	Hib	Pediarix®	DTaP + Hep B + IPV	RotaTeq®	Rotavirus (RV5)
Afluria®	Flu	FluLaval®	Flu	HibTITER®	Hib	PedvaxHIB®	Hib	Tenivac®	Td
Bexsero®	MenB	FluMist®	Flu	Ipol®	IPV	Pentacel®	DTaP + Hib + IPV	Trumenba®	MenB
Boostrix®	Tdap	Fluvirin®	Flu	Infanrix®	DTaP	Pneumovax®	PPSV	Twinrix®	Hep A + Hep B
Cervarix®	2vHPV	Fluzone®	Flu	Kinrix®	DTaP + IPV	Prevnar®	PCV	Vaqta®	Hep A
Daptacel®	DTaP	Gardasil®	4vHPV	Menactra®	MCV or MCV4	ProQuad®	MMR + Varicella	Varivax®	Varicella
Engerix-B®	Hep B	Gardasil® 9	9vHPV	Menomune®	MPSV4	Recombivax HB®	Hep B		

If you have a disability and need this document in another format, please call 1-800-525-0127 (TDD/TTY call 711).

DOH 348-013 December 2016

EXHIBIT 3
CONFIDENTIAL INCOME STATEMENT
HOUSEHOLD APPLICATION FOR FREE AND REDUCED-PRICE MEALS

1. List **all children** living with you (except Foster Children). Include any income received and make an "x" in the correct box for how often it is received. If you have written a case number for any of your children, skip to **Section 5. See Section 4 for Foster Child**. (You must submit a separate application for each Foster Child).

Child's Last Name	Child's First Name	MI	Date of Birth	Child Income	Weekly	Every 2 Weeks	Twice a Month	Monthly	No Income	Does your child receive Basic Food, TANF or FDPIR? If YES, you must list a case number.
				$						☐ Yes-Case # _____
				$						☐ Yes-Case # _____
				$						☐ Yes-Case # _____
				$						☐ Yes-Case # _____
				$						☐ Yes-Case # _____

2. List the names of all other household members - Please enter your income and CHECK how often it is received. If you write a case number, skip to Section 5.

Names of ALL other household members (do not include names of children listed above)	No Income	Earnings from work (before any deductions)	Weekly	Every 2 Weeks	Twice a Month	Monthly	Welfare, Child Support, Alimony	Weekly	Every 2 Weeks	Twice a Month	Monthly	Pensions, Retirement, Social Security (SSI)	Weekly	Every 2 Weeks	Twice a Month	Monthly	Any Other Income Not Already Listed	Weekly	Every 2 Weeks	Twice a Month	Monthly	Does any adult receive Basic Food, TANF, of FDPIR? If YES, you must list a case number.
		$					$					$					$					
		$					$					$					$					
		$					$					$					$					
		$					$					$					$					
		$					$					$					$					

3. Total Household Members (include all people living in your household): _____

4. Foster Child – One Foster Child per application. List the foster child below, **child's personal income and how often received.** If foster child has no income write "0".

Foster Child's Name	Date of Birth	Child's Personal Income	☐ Weekly	☐ Every 2 wk.	School	Grade
		$	☐ Twice a mo.	☐ Monthly		

5. Signature and Social Security Number – I certify that all of the above information is true and correct and that all of the income is reported and/or the Basic Food or TANF/FDPIR case number is reported correctly. I understand that this information is being given for the receipt of federal funds; that school 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.

_____
Printed Name of Adult Household Member

_____
Signature of Adult Household Member

_____
Date

Check the box if you *do not* have a social security number

☐ I do not have a social security number.

_____ - _____ - _____
Social Security Number

_____ Mailing Address

_____ Street Address (if different from mailing)

_____ City & Zip

_____ Home Phone Number

_____ Work Phone Number

_____ Email Address

6. Children's Racial And Ethnic Identities (Optional)

Attachment 22

Mark one or more racial identities:

- ☐ Asian
- ☐ White
- ☐ Black, or African American
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other

Mark one ethnic identity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

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. You must include the social security number of the 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 (Basic Food), 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.

OFFICIAL USE ONLY
DO NOT WRITE BELOW THIS LINE

ANNUAL INCOME CONVERSION: Weekly x 52; Every Two Weeks x 26; Twice a Month x 24; Monthly x 12

APPROVAL/DENIAL

- ☐ Basic Food/TANF/FDPIR Household — Total Household Size _____
- ☐ Income Household — Total Household Income $_____
- ☐ Foster Child — Income Approved by (circle one): weekly every two weeks twice a month monthly annual

APPLICATION APPROVED FOR:

- ☐ Free Meals
- ☐ Reduced-Price Meals

APPLICATION DENIED BECAUSE:

- ☐ Income Over Allowed Amount
- ☐ Incomplete/Missing Information
- ☐ Other:_____

Date Notice Sent	Signature of Approving Official	Date

"In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability."

"To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue SW, Washington, D.C. 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer."

RAY OF HOPE PARTIAL SCHOLARSHIP APPLICATION

Name of Parent/Guardian: _____

Name of Child(ren): _____

Please return to Rebound within one week of receipt. Partial scholarships are distributed on a proven need (via verifiable proof of income) and a first come, first served basis. Please submit your complete, accurate forms by Tuesday May 15th, 2018 in order to be considered for scholarship.

- ***Applications received after May 15th may not be considered for scholarship money***
- ***Incomplete or inaccurate information will nullify your application***

We want to be excellent stewards of the limited financial resources available to us. We also want to help you, and to do so we need you to help us. To do this, we ask every family to:

1. **Pursue state childcare benefits first**
   a. If you qualify for benefits, this will likely cover approximately half of the full amount of tuition.
      Please initial here if you know you do NOT have state benefits _____

2. **Funding from Community Sources**
   a. There are a number of community organizations that can help contribute to your child(ren)'s tuition. The more funding you can find in the community, the less will come out of your pocket, and our limited scholarship funds. If you are involved with any of the following organizations, please contact them to see if funds are available to you:
      i. Blue Skies for Children (360-756-6710)
      ii. Opportunity Council (360-734-5121)
      iii. Catholic Community Services (360-676-2164)
      iv. Lummi Nation Family Services (360-312-2133)
      v. Your Local Church
      vi. Family or Friends

   We strongly recommend that you START NOW with contacting these agencies.

3. **Your financial contribution toward your child(ren)'s Ray of Hope tuition**
   a. The amount of this contribution is calculated based on your monthly income, the number of people living in your household, and how many children are attending the program. (Confidential Income Statement is attached to the full child application).
   b. The parent contribution is between $250-$700 per child depending on the above factors. Once we receive your full application (scholarship app + child app), we will figure out the amount, contact you, and set up a payment plan.
      If a payment is missed, your child(ren) will be dismissed from camp until payment has been received.

RAY OF HOPE PARTIAL SCHOLARSHIP APPLICATION

4. Family/Household Information:

Has your family been a recipient of a Ray of Hope partial scholarship before?
No ☐ Yes ☐ When:_____ How much:_____

How many people currently live in your household?
Adults (include self): _____ Children: _____ Total:_____

How many children are you applying for to receive a partial scholarship? List Name(s): _____

---

5. Why are you requesting this scholarship?

Please tell us a little bit about why you desire your child to attend Ray of Hope. You can include information about their past, your current situation, what you desire for your child, what this could mean for your child, etc. Please keep it to no more than four paragraphs. This helps us understand how the limited scholarship funds can be best utilized. ***Please use a separate piece of paper.***

6. Scholarship Requirements – Ray of Hope Family Enrichment Program

If your family is awarded a partial scholarship, Rebound requires at least one parent to attend the Ray of Hope Family Enrichment Program on Tuesday evenings for five of the six weeks of camp.

Please initial here that you understand and are required to attend Ray of Hope Family Enrichment Program every week _____

7. Payment Information:

If your family is awarded a partial scholarship, you will be notified by a Rebound Staff member who will detail your payment requirements. Please know that every family will be required (whether full pay or with a scholarship) to adhere to the payment schedule listed below. Failure to do so will result in your child's participation in camp being revoked.

If not paid in full by August 2nd, your child(ren) will not be able to participate in the last day of camp (Birch Bay Waterslides) and will not be able to attend future camps until paid.

By signing below, I acknowledge that the information in this application is current and accurate; that I am authorized to communicate with Rebound of Whatcom County regarding payment for Ray of Hope; and that submitting this application does not guarantee either my child's enrollment in the program, or receipt of partial scholarship.

Signed: _____ Date: _____