Hear Indiana Listening and Spoken Language Camp 2019

Hello 2019 campers! We are thrilled to announce that our 2019 Listening and Spoken Language Camp will be held at Happy Hollow Children's Camp, in Nashville, IN from June 16-June 21st 2019. Please note we need ALL the below documents by May 10, 2019 in order for your child to attend camp. Please email HearCamp@HearIndiana.org with any questions.

What is needed for registration?

- ☐ **Part One: 2019 Camp Deposit form (online at www.HearIndiana.org/camp)**
- ☐ **Part Two: 2019 Camp Application and Fee form (online at www.HearIndiana.org/camp)**
- ☐ **$50 deposit (paid while completing Part One: 2019 Camp Deposit form)**
- ☐ **$500 camper fee (instate)/$800 camper fee (out of state)**
  (Paid during Part Two: 2019 Camp Application and Fee form)

- ☐ **Part Three: 2019 Camper Paperwork Packet**
  - ☐ Important Camper Information Form
  - ☐ Bully Prevention Contract
  - ☐ Behavior Expectation Contract
  - ☐ Health History Form (pages 1-4; including immunization records)
  - ☐ Doctor/Nurse Practitioner Form (MUST be signed by a doctor or nurse practitioner)
  - ☐ Global Release/Agreement for Happy Hollow Children's Camp and Hear Indiana
  - ☐ Food Service Form
- ☐ **Copy of insurance card (front and back)**
- ☐ **Digital photo of camper (emailed to HearCamp@HearIndiana.org)**

Completed Packet due by May 10, 2019!

Please return ALL PAPERWORK by mail, email, or fax to:

Hear Indiana, Attn: Listening Spoken Language Camp
4740 Kingsway Drive
Suite 33,
Indianapolis, IN 46205

HearCamp@HearIndiana.org
Phone: (317) 828-0211
Fax: (888) 887-0932

Financial aid information: If you are interested in applying for financial aid, please confirm you qualify by using the sliding fee scale below. To apply for financial aid and to receive your discount code for your online Part Two: 2019 Camp Application and Fee form, please email the front page of your most recent tax return to HearCamp@HearIndiana.org

Annual Gross Income			Size of Family												
			1	2	3	4	5	6	7	8	9	10	11	12	13
$0	-	$12,060	0%												
$12,061	-	$22,511	20%	0%											
$22,512	-	$32,962	40%	20%	0%										
$32,963	-	$43,413	60%	40%	20%	0%									
$43,414	-	$53,864	80%	60%	40%	20%	0%								
$53,865	-	$64,315	100%	80%	60%	40%	20%	0%							
$64,316	-	$74,766		100%	80%	60%	40%	20%	0%						
$74,767	-	$85,217			100%	80%	60%	40%	20%	0%					
$85,218	-	$95,668				100%	80%	60%	40%	20%	0%				
$95,669	-	$106,119					100%	80%	60%	40%	20%	0%			
$106,120	-	$116,570						100%	80%	60%	40%	20%	0%		
$116,571	-	$127,021							100%	80%	60%	40%	20%	0%	
$127,022	-	$137,472								100%	80%	60%	40%	20%	0%
$137,473	-	$147,923									100%	80%	60%	40%	20%
$147,924	-	$158,374										100%	80%	60%	40%
$158,375	-	$168,825											100%	80%	60%
$168,826	-	$179,276												100%	80%
$179,277	-	$189,727													100%

Important Camper Information

Camper First Name: _____ Camper Last Name: _____ Camper Birth Date: _____

Parent/Guardian One First and Last Name: _____ Phone Number: _____

Parent/Guardian Two First and Last Name: _____ Phone Number: _____

Camper Address: _____ Camper City: _____

Camper State: _____ Camper Zip: _____

Please list emergency contacts in the box:

Who is authorized to pick up your camper at the end of camp? Please list all who apply.
Note: A picture ID will be required at pick-up.

Please list any special dietary requirements in the box.

For office use only. Please do not write in this box.

Assigned drop-off time: _____ Cabin Assignment: _____

Happy Hollow Children's Camp
Bully Prevention
Parent and Camper Contract

_____ _____

(Parent/ Guardian Name) (Child's Name)

We agree that he/she will not participate or engage in any bullying activity on or off camp property in which the conduct may reasonably carry-over into the camp setting and/or interfere with the safety of all children attending camp.

We understand the definition of bullying

1. Any aggressive or negative gesture, or written, verbal or physical act that places another student in reasonable fear of harm to his or her person or property;
2. Any aggressive or negative gesture, or written, verbal or physical act that has the effect of insulting or demeaning any camper in such way as to disrupt or interfere with the Happy Hollow's educational mission;
3. Any assertion of physical or psychological power over, or cruelty to, another camper;
4. Any behaviors including but not limited to pushing, hitting, threatening, name-calling or other physical or verbal conduct of a belittling or intimidating nature;

We, the undersigned, acknowledge and understand the expectation and potential consequences for my child in the above parent and camper contract. We further understand that if my child demonstrates and/or participates in bullying behavior, the behavior will result in the following disciplinary action:

1st Offense: Camper's name will be reported to a camp administrator. The (Parent/ Guardian) will be contacted to discuss the situation.

2nd Offense: Camper's name will be reported to a camp administrator and my child will be asked to leave camp.

I (Parent/ Guardian) will arrange for the transportation for my child to leave camp and return home. If I (Parent/ Guardian) or emergency contact cannot be reached within a 24 hour period of time Happy Hollow Children's Camp Inc. a camp administrator has the right to contact Child Protective Services.

Camper Signature_____ Date _____

Parent Signature_____ Date _____

Happy Hollow Children's Camp
Behavior Rules and Expectations
Parent and Camper Contract

_____ _____

(Parent/ Guardian Name) (Camper's Name)

We agree that he/she will be expected to follow rules and expectations while on or off camp property in which the behavior may reasonably carry-over into the camp setting and/or interfere with the safety of all campers attending Happy Hollow Children's camp. These expectations help to ensure a pleasant experience for all of our campers, volunteers, and staff.

CAMP RULES APPLY FROM CHECK-IN UNTIL CAMPER IS PICKED UP.

BEHAVIOR RULES AND EXPECTATIONS

Treat all others with courtesy and respect.
Fighting is not allowed.
Use appropriate language (no cursing).
Everyone helps to keep camp clean.
Everyone is expected to take turns with chores.
Everyone participates in activities chosen by the cabin group.
The buddy system is used for safety.

We, the undersigned, acknowledge and understand the expectation and potential consequences for my child in the above parent and camper contract. We further understand that if my child demonstrates and/or participates in inappropriate behavior, the behavior will result in the following disciplinary action:

1st Offense: Camper's name will be reported to a camp administrator. The (Parent/ Guardian) will be contacted to discuss the situation.

2nd Offense: Camper's name will be reported to a camp administrator and my child will be required to leave camp.

I (Parent/ Guardian) will arrange for the transportation for my child to leave camp and return home. If I (Parent/ Guardian) or emergency contacts cannot be reached within a 24 hour period of time a Happy Hollow Children's Camp Inc. administrator has the right to contact Child Protective Services.

Camper Signature_____ Date _____

Parent Signature_____ Date _____

Health History Form
Page 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Dates will attend camp: from _____ (Month/Day/Year) to _____ (Month/Day/Year)

Camper Name: _____ (First) _____ (Middle) _____ (Last)

☐ Male ☐ Female Birth Date _____ (Month/Day/Year) Age on arrival at camp: _____

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

1) ***Complete Health History Form pages 1, 2 and 3.***
2) ***You do not need to complete Health History Form page 4 (will be used for camp check-in).***
3) ***Complete the top of Doctor/Nurse Practitioner Form. The bottom of the Doctor/Nurse Partitioner form must be reviewed and signed by your child's health-care provider.***
4) ***After it has been completed and signed by your child's health-care provider, return completed packet to Hear Indiana by May 10th 2019.***

Camper Home Address: _____ (Street Address) _____ (City) _____ (State) _____ (Zip Code)

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) _____ (_____) _____

Email: _____

Home Address: _____ (If different from above) (Street Address) (City) (State) (Zip Code)

Second parent/guardian or other emergency contact:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) _____ (_____) _____

Email: _____

Additional contact in event parent(s)/guardian(s) can not be reached:

Name(s): _____ Relationship to Camper: _____ Preferred Phones: (_____) _____ (_____) _____

Allergies: ☐ No known allergies. ☐ This camper is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other
(Please describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition: ☐ This camper eats a regular diet. ☐ This camper eats a regular vegetarian diet.
☐ This camper has special food needs. ***(Please describe below.)***

Restrictions: ☐ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
☐ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. ***(Please describe below.)***

Medical Insurance Information:

This camper is covered by family medical/hospital insurance ☐ Yes ☐ No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company_____ Policy Number_____

Subscriber_____ Insurance Company Phone Number (_____) _____

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian _____ Date: _____ Relationship to Camper: _____

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

Camper Name First Middle Last

(For Camp Use) Cabin or Group _____

(For Camp Use) Session Code(s): _____

Health History Form- Page 2

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

Immunization History: Provide the month and year for each immunization. Starred (★) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis★ (DTaP) or (TdaP)						
Tetanus booster★ (dT) or (TdaP)						
Mumps, measles, rubella★ (MMR)						
Polio★ (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) ☐Had chicken pox Date:						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date:	☐ Negative	☐ Positive

If your camper has not been fully immunized, please sign the following statement: **I understand and accept the risks to my child from not being fully immunized.**

Signature of Custodial Parent/Guardian: _____ Date: _____ Relationship to Camper: _____

Medication: ☐ This camper will not take any daily medications while attending camp.

☐ This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. ***Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.***

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_____		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_____		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_____		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. ***Cross out those the camper should not be given.***

Acetaminophen (Tylenol)
Phenylephrine decongestant (Sudafed PE)
Antihistamine/allergy medicine
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Sore throat spray
Lice shampoo or cream (Nix or Elimite)
Calamine lotion
Laxatives for constipation (Ex-Lax)
Ibuprofen (Advil, Motrin)
Pseudoephedrine decongestant (Sudafed)
Guaifenesin cough syrup (Robitussin)
Dextromethorphan cough syrup (Robitussin DM)
Generic cough drops
Antibiotic cream
Aloe
Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

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Health History Form- Page 3

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

General Health History: ***Check "Yes" or "No" for each statement. Explain "Yes" answers below.***

Has/does the camper:

1. Ever been hospitalized?	☐ Yes	☐ No	11. Had fainting or dizziness?	☐ Yes	☐ No
2. Ever had surgery?	☐ Yes	☐ No	12. Passed out/had chest pain during exercise?	☐ Yes	☐ No
3. Have recurrent/chronic illnesses?	☐ Yes	☐ No	13. Had mononucleosis ("mono") during the past 12 months?	☐ Yes	☐ No
4. Had a recent infectious disease?	☐ Yes	☐ No	14. If female, have problems with periods/menstruation?	☐ Yes	☐ No
5. Had a recent injury?	☐ Yes	☐ No	15. Have problems with falling asleep/sleepwalking?	☐ Yes	☐ No
6. Had asthma/wheezing/shortness of breath?	☐ Yes	☐ No	16. Ever had back/joint problems?	☐ Yes	☐ No
7. Have diabetes?	☐ Yes	☐ No	17. Have a history of bedwetting?	☐ Yes	☐ No
8. Had seizures?	☐ Yes	☐ No	18. Have problems with diarrhea/constipation?	☐ Yes	☐ No
9. Had headaches?	☐ Yes	☐ No	19. Have any skin problems?	☐ Yes	☐ No
10. Wear glasses, contacts, or protective eyewear?	☐ Yes	☐ No	20. Traveled outside the country in the past 9 months?	☐ Yes	☐ No

***Please explain "Yes" answers in the space below*,** noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Mental, Emotional, and Social Health: ***Check "Yes" or "No" for each statement.***

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?	☐ Yes	☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?	☐ Yes	☐ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?	☐ Yes	☐ No
4. Had a significant life event that continues to affect the camper's life? (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)	☐ Yes	☐ No

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Health-Care Providers:

Name of camper's primary doctor(s): _____ Phone: (_____) _____

Name of dentist(s):_____ Phone: (_____) _____

Name of orthodontist(s):_____ Phone: (_____) _____

What Have We Forgotten to Ask? ***Please provide in the space below*** any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program***. Attach additional information if needed.***

Parents/Guardians: STOP here. The rest of this is form is completed when the camper arrives at camp. Keep a copy for your records.

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Health History Form- Page 4

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

Individual Health Record (For Camp Use Only)

Initial Screening **Date/Time: _____** **Initials: _____**

☐ **Screening** has been conducted according to camp protocol and significant findings noted as follows:

A. Any signs/symptoms of illness or injury upon arrival?..... ☐ No ☐ Yes as noted below

B. History of exposure to communicable disease?..... ☐ No ☐ Yes as noted below

C. Additions or corrections to information on this health history?..... ☐ No ☐ Yes as noted below

D. Medication given to health-care staff?..... ☐ No ☐ Yes as noted below

E. Any signs/symptoms of head lice?..... ☐ No ☐ Yes as noted below

Provider notes: (date/time/initial all entries) _____

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Exit Note: Check one of the following:

☐ Left camp this day with no reported illness or injury symptoms.

☐ Left camp this day with the following problem/concern:

_____

_____

This person was told about the problem and instructed about follow-up as noted above: _____

Date/Time: _____ Initials: _____

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Doctor/Nurse Practitioner Form (Dr/NP Signature Required)

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

This is the only form your Doctor/Nurse Practitioner needs to sign.

***To Parent(s)/Guardian(s): Complete this section** and give **this form** and **a copy of your completed Health History Form (pages 1-3)** to your child's health-care provider for review.*

Dates will attend camp: from _____ to _____
Month/Day/Year Month/Day/Year

Camper Name: _____
First Middle Last

☐ Male ☐ Female Birth Date _____ Age on arrival at camp _____
Month/Day/Year

Camper home address: _____

_____
City State Zip Code

Custodial parent(s)/guardian(s) phone: (_____)_____ (_____)_____

Parent(s)/guardian(s) stop here. Rest of form to be completed by medical personnel.

The following non-prescription medications are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and injury. ***Medical personnel: Cross out those items the camper should not be given.***

Acetaminophen (Tylenol)
Ibuprofen (Advil, Motrin)
Phenylephrine (Sudafed PE)
Pseudoephedrine (Sudafed)
Chlorpheneramine maleate
Guaifenesin
Dextromethorphan
Diphenhydramine (Benadryl)
Generic cough drops
Chloraseptic (Sore throat spray)
Lice shampoo or scabies cream (Nix or Elimite)
Calamine lotion
Bismuth subsalicylate (Pepto-Bismol)
Laxatives for constipation (Ex-Lax)
Hydrocortisone 1% cream
Topical antibiotic cream
Calamine lotion
Aloe

Medical Personnel: Please review the CAMPER HEALTH HISTORY FORM (FORM 1) and complete all remaining sections of this form (FORM 2). Attach additional information if needed.

Physical exam done today: ☐ Yes ☐ No (**If "No," date of last physical**: _____)
Month/Day/Year

ACA accreditation standards specify physical exam within last 24 months.

Weight: _____ lbs Height: _____ft_____in Blood Pressure_____/_____

Allergies: ☐ No Known Allergies

☐ To foods ***(list):***

☐ To medications: ***(list):***

☐ To the environment ***(insect stings, hay fever, etc.– list):***

☐ Other allergies: ***(list):***

Describe previous reactions:

Diet, Nutrition: ☐ Eats a regular diet. ☐ Has a medically prescribed meal plan or dietary restrictions:***(describe below)***

The camper is undergoing treatment at this time for the following conditions: ***(describe below)*** ☐ None.

Medication: ☐ No daily medications. ☐ Will take the following prescribed medication(s) while at camp: ***(name, dose, frequency—describe below)***

Other treatments/therapies to be continued at camp: ***(describe below)*** ☐ None needed.

Do you feel that the camper will require limitations or restrictions to activity while at camp? ☐ No ☐ Yes

If you answered "Yes" to the question above, what do you recommend? ***(describe below—attach additional information if needed)***

"I have reviewed the Health History Form (pages 1-3), and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)

Name of licensed provider (please print): _____ Signature: _____ Title: _____

Office Address _____
Street City State Zip Code

Telephone: (_____)_____ Date: _____

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Camper Name First Middle Last

(For Camp Use) Cabin or Group _____

(For Camp Use) Session Code(s): _____

Camper's Name: _____

1.) The Happy Hollow Children's Camp (HHCC) reserves the right to deny participation to any activity or overnight in which HHCC, in its sole discretion, deems the participation or presence of the camper would be dangerous or distracting to the camper, to the other campers, or to staff members.

2.) For the safety and general welfare of all the campers, the HHCC reserves the unrestricted right to dismiss the camper and terminate the enrollment of the camper if his or her conduct or influence, in the sole opinion of the HHCC is not in the best interests of the HHCC or other campers without providing refund.

3.) For benefit of the camper, the HHCC should be made aware of any treatment for emotional, neurological, physical, or psychiatric disorders and/or any restrictions of the camper's activities and the parent/guardian agrees to give written notice to the HHCC of any such conditions. If the camper presents a risk to himself/herself or others, the camper may be discharged at the sole discretion of the HHCC.

4.) Medical forms and (Authorization for Medical Treatment) must be submitted to Hear Indiana (HI) prior to May 10, 2019. Medical professionals will review these forms. The camper will not be allowed to begin camp without up-to-date and complete medical forms and Authorization for Medical Treatment on file with the HHCC and HI.

5.) In the rare circumstance that the HHCC determines that it cannot provide adequate supervision or facilities for your child (up to and including check-in day), it reserves the right to terminate enrollment of such campers. In those rare cases, a refund will be given.

6.) The HHCC has the right to share medical information with all staff members when medically necessary.

7.) The HHCC will not be responsible for loss or damage of valuables or personal articles including, but not limited to, cash, jewelry, clothing, electronic devices, audiological equipment, and athletic equipment.

8.) The HHCC shall have the right to terminate this Agreement in the event that the Parent/Guardian has made any misrepresentation on the camper registration or medical form. The HHCC will not make refunds if this occurs.

9.) The Parent/Guardian executing this Agreement acknowledges and agrees that if the camp season is canceled or shortened due to Acts of God (by way of example and without limitation: flood, hurricane, earthquake, tornado, or other natural disaster), war, terrorism, strike, order of civility, epidemic illness, or any other reason beyond the HHCC's control or if the HHCC determines not to open camp, the

HHCC shall not be liable for any consequential or other damage of any kind or nature. The refund of tuition, if any, in whole, or in part, shall be in the sole discretion of HHCC.

10.) The Parent/Guardian who signs this agreement represents that s/he has full authority to do so and will be responsible for payment of all camp fees.

11.) I hereby grant permission for my child to participate in the activities of HI's camp at HHCC. I recognize that while precautions will be taken for the safety of my child and other campers, children's outdoor camping include physical activity and no activity can be rendered completely without risks. My child will be expected to participate in activities chosen by his/her group to cooperate with and be courteous to fellow campers as well as staff and volunteers. I understand that inappropriate behavior will not be tolerated and that my child may be barred from future participation and/or returned home for serious reasons (fighting, failure to follow rules, etc.). I agree to release, indemnify, defend, and hold harmless HHCC and HI, their boards, staff, agents, and volunteers from any damage resulting from the actions of my child. I also grant permission to staff, volunteers, or agents of HHC to transport my child as necessary for reasons of the camping program or safety while attending HHCC.

12.) I hereby give permission for my child to be interviewed, photographed, videotaped, and/or recorded while participating in the programs of HI's camp at HHCC and for her/his image/comments to be used for purposes of camp reporting, promotion, advertisement or illustration. Use of any such photographs, videotapes, or interviews may include, but are not limited to, use on Internet Websites, social media, promoting or reporting on American Camp Association, HHCC and/or HI.

13.) Camper Funding Release (optional):
HHCC and HI receive donations to fund our program. Our funders often request data about our campers. For HHCC and HI to receive grant funding for camp programs, I hereby authorize HHCC and HI to release the following information: Child's name and last initial, address, dates attended camp and camp evaluation. I understand that the information will be handled confidentially with all applicable federal laws. I understand that I can revoke the authorization at any time by written, dated communication. **If you agree please initial here _____.**

I have read the above Agreement and understand its terms and consent and agree to the same.

_____ _____
Parent or Guardian Signature Date

_____
Printed Name

Prescribed by State Board of Accounts | School Form No. 521 / 2016

[insert school corporation name] | [insert corp. #]

SCHOOL CORPORATION | CORP. NUMBER

APPLICATION FOR TEXTBOOK ASSISTANCE AND OTHER ASSISTANCE

Effective July 1, 20__ __ - One Application per **Household**

Part 1. Names of **all** household members (First, Middle Initial, Last)	Only for students: Check if living with parent or caretaker relative	Only for students: Name of each child's school	Only for students: Grade	Only for students: Birthdate	Only for students: Check if a Foster child	Check if no income
	☐				☐	☐
	☐				☐	☐
	☐				☐	☐
	☐				☐	☐
	☐				☐	☐
	☐				☐	☐
	☐				☐	☐
	☐				☐	☐
	☐				☐	☐
If ALL children listed above are foster children, skip to Part 5 and sign.						

Part 2. If any member of your household (student, adult or non-student) has a valid Food Stamp (SNAP) or TANF case number, please provide the name of the person who receives benefits, check the box indicating the benefit program, and enter the case number, then skip to Part 5. If no one receives these benefits, skip to Part 3.

Name: _____ **Food Stamp** ☐ **TANF** ☐ **Case Number:** ___/___/___/___/___/___/___/___/___/___

Part 3. If any child you are applying for is migrant, homeless, or runaway, check the appropriate box and call [school's homeless liaison/migrant coordinator] at [phone number]. **Migrant** ☐ **Homeless** ☐ **Runaway** ☐

Part 4.	**Section 2** TOTAL HOUSEHOLD GROSS INCOME (BEFORE DEDUCTIONS). LIST ALL INCOME ON THE SAME LINE AS THE PERSON WHO RECEIVES IT. CHECK THE BOX FOR HOW OFTEN IT IS RECEIVED. RECORD EACH INCOME ONLY ONCE. **GROSS INCOME and HOW OFTEN IT WAS RECEIVED** *Examples: $100 / monthly or $100 / every 2 weeks or $100 / twice a month or $100 / weekly*																			
Section 1 NAME (List **ONLY** household members with income)	Earnings from Work Before Deductions	Weekly	Every 2 wks.	Twice A Month	Monthly	Welfare, Child Support, Alimony	Weekly	Every 2 Wks.	Twice A Month	Monthly	Social Security, SSI, VA, Retirement Benefits	Weekly	Every 2 Wks.	Twice A Month	Monthly	All Other Income such as Unemployment	Weekly	Every 2 Wks	Twice A Month	Monthly
Example: Jane Smith	*$ 200*	☐	☒	☐	☐	*$ 150*	☒	☐	☐	☐	*$ 100*	☐	☐	☐	☒	*$ 50*	☐	☐	☐	☒
1.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
2.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
3.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
4.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
5.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
6.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
7.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

Part 5. Do you want to receive textbook assistance? Yes_____ No _____

Part 6. SIGNATURE: My signature below authorizes the release of information on this application for textbook assistance. I give up my right of confidentiality for this purpose only. The application may be subject to audit by the State of Indiana to determine student eligibility for textbooks. The application information may be shared with the Indiana Family and Social Services Administration pursuant to I.C. 20-33-5-2 and I.C. 12-14-28-2, solely for purposes of complying with 45 C.F.R. PARTS 260 AND 265 and for the purpose of identifying children who may qualify for free or low-cost health insurance under Medicaid or Hoosier Healthwise. I certify that I am the parent/guardian of the child(ren) for whom application is being made and authorize the release of information for the purposes outlined in the application.

_____ (printed name)

_____ xxx-xx-__ __ __ __ (last 4 digits of social security number)

_____ **(Signature)**

_____ **(Date)**

School Use Only:
___ Approved
___ Denied
___ Not applicable

Part 7. RACE AND ETHNICITY:
Optional - You are not required to answer this question. No child will be discriminated against because of race, color, sex, national origin, age, or disability.

Mark one or more racial identities:
- ☐ Asian
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

Mark one ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Part 8. For information about Hoosier Healthwise health insurance, call 1-800-889-9949.

FOR SCHOOL USE ONLY – DO NOT WRITE BELOW THIS LINE

INCOME CONVERSION to YEARLY:	WEEKLY INCOME X 52	
EVERY 2 WEEKS X 26	TWICE A MONTH X 24	MONTHLY INCOME X 12

ELIGIBILITY DETERMINATION

Income Eligibility: Total Household Size:_____ Total Income:$_____ per: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Twice a Month ☐ Yearly

OR Categorical Eligibility: ☐ Food Stamps ☐ TANF ☐ Migrant ☐ Homeless ☐ Runaway ☐ Foster

Eligibility Determination: ☐ Approved ☐ Denied

Reason for Denial: ☐ Income Too High ☐ Incomplete Application ☐ Other(Reason)_____

Signature of Determining Official:_____ Date:_____

Date Withdrawn: _____

VERIFICATION

Confirmation Review Official: _____

Date Verification Notice Sent:_____ Date Response Due from Households:_____ Date Second Notice Sent (or N/A): _____	Approval Based On: ☐ Food Stamps / TANF Case Number ☐ Household Size and Income ☐ Other _____	Verification Results: ☐ No Change ☐ Free to Reduced ☐ Free to Paid ☐ Reduced to Free ☐ Reduced to Paid	Reason for Change: ☐ Income:_____ ☐ Household Size: _____ ☐ Change in Food Stamps /TANF ☐ Did not respond ☐ Other: _____	Date Notice of Change Sent:_____ Date Change Made:_____

Date Hearing Requested:_____
Hearing Decision: _____

Verifying Official's Signature:_____
Date:_____

Use of Information Statement: This explains how we will use the information you give us.
The information contained in the application will be used to determine eligibility for textbook assistance under Indiana Code 20-33. You do not have to provide the information, but if you do not, we cannot approve your child for textbook assistance. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of 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 the State of Indiana school textbook program. 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.