

(Date Mailed)



Human Services, Inc.  
Child Care Development Fund

## GREAT OPPORTUNITY TO RE-CERTIFY BY MAIL.

When completing the re-certification by mail, you must include the application checklist with all of the required information. **All information submitted must be free from all whiteout and/or highlighting, and must be legible.** You must sign your first and last name on all documents. (No initials or what looks like initials can be accepted).

**\*\*Important Please Read!! Please do not date parent /applicant worksheet & other forms enclosed more than 28 days prior to termination date. Provider page cannot be dated after application date and must be completed in full by your provider. All forms in this packet must be dated after ( ) in order to be accepted.**

If you need any additional forms, they are available at the reception desk at your local county office. (Except Brown Co., please call phone# at bottom of page). Be sure to put enough postage on your envelope so that the packet is not returned to you. Also, you are welcome to drop paperwork off at the reception desk at the Bartholomew County Office located at 1585 Indianapolis Rd. in Columbus, Indiana. **Sorry, other county offices cannot accept paperwork.**

**Complete information must be received by our Columbus Office at the address located at bottom of page by: ( ) or you will lose your CCDF vouchers.**

Once we receive your re-certification paperwork it will be processed, and if you qualify for services you will receive a NEW "pre-voucher report". You must ensure you receive this NEW voucher report prior to your current voucher termination date. Do not risk losing your childcare voucher. **TURN IN PAPERWORK REQUESTED ON TIME AND READ CHECKLIST TO MAKE SURE YOU ARE SUBMITTING ALL REQUIRED DOCUMENTATION.**

**If you do not re-certify, you will be terminated from the program.**

**This mail-in re-certification cannot be faxed.**

Human Services, Inc. Attn: CCDF,  
P.O. Box 588, Columbus, IN 47202-0588  
(800) 296-8026 / (812) 372-8407  
[www.hsi-indiana.com](http://www.hsi-indiana.com)

**\*\*Mail in Application Checklist – (Important please read each item carefully and follow instructions).\*\***  
All paperwork signed by you **MUST** reflect your full name and the name must match your proof of identity.

The following enclosed items must be completed and returned:  
(Place check mark in each box)

- Mail-In Application Checklist (this letter) **be sure to follow instructions at top and bottom of page.**
- Parent/Applicant Worksheet (enclosed) **complete, sign full name & date (NO INITIALS PLEASE)**
- Parent Statement/Rights & Obligations form (enclosed) **be sure to sign full name & date.**
- Provider Information Page (enclosed) **completed by your child care provider – must be complete.**
- Child Support Declaration Form (enclosed) **all applicants must complete this form. Sign full name & date. We no longer need print-out from child support office.**
- Name Attestation Form (enclosed) **leave blank at top, just sign full name & date at bottom of page.**
- Client Characteristic Survey (enclosed) - **complete front and back side of form.**
- Proof of Date of Birth for all children in household. **(Copy of Birth Certificate or Birth Confirmation Letter).**  
Copies of Hoosier Healthwise cards are no longer accepted.

**You must also include the following: Place a check mark or N/A in each box**

- All pay stubs for all parents in the household for **30 days PRIOR to the date you SIGN the worksheet** - the last 4 consecutive pay stubs if you are paid weekly or the last two consecutive pay stubs if you are paid twice a month. **Check stubs submitted cannot be for a pay date that is after the date you write on your parent/applicant worksheet. Must be the prior 30 DAYS EXACTLY.**
- Important!!** Pay stubs must show your name, the date paid (we cannot use ending date), hours worked, and gross amount earned. If this information is not on the pay stub please pick up a wage verification form at your local office and have your employer complete and submit with copies of check stubs. If you are self employed, you will need to pick up a profit/loss form to complete.
- Verification of residency**, most current utility bill in your name, or a copy of current driver's license / state i.d., or a postmarked envelope, including **postmark dated w/in 30 days prior of application date. (Must be envelope, not the letter you received)**. **No window envelopes accepted.**
- School schedule, if applicable, for all ADULT household members. This must indicate the name of the school, the name of the student, credit hours, class days and times, and the semester begin/end dates.
- If you work for your child's daycare provider, you must submit a letter **signed by you and the daycare** that you do NOT work with your own children. Letter must be dated w/in 30 days prior to application date. We cannot accept a letter that is dated after the date you place on your parent worksheet.

**Documentation of any other income that you have received in the past 30 days PRIOR to the date you SIGN the worksheet such as:**

- SSI / Social Security –current award letter.
- TANF income /TANF Impact referral – if you are on TANF. **YOU MUST REQUEST THIS PRINT-OUT FROM YOUR CASEWORKER and enclose it yourself.**

**IMPORTANT, PLEASE READ!** Please note that if any items are missing which are not marked N/A, your application will be denied. **We will not send out a 2<sup>nd</sup> notice or make phone calls regarding items missing.** It is your responsibility to ensure that all items are submitted.



## Parent/ Applicant Worksheet (Child Care and Development Fund Voucher Program)

<b>Parent Name:</b>	<b>AIS Case Number:</b>	<b>Parent Birth Date:</b>	<b>SSN (optional):</b>	<b>Home Phone, including area code:</b>
<b>Street Address:</b>	<b>City:</b>	<b>Zip:</b>	<b>County:</b>	<b>Other Phone, contact number:</b>

<b>List all adults in household: First Name, Last Name</b>	<b>Birth Date:</b>	<b>SSN (optional):</b>	<b>Specify Relationship to Parent:</b>	<b>Working Yes or No</b>	<b>School Yes or No</b>	<b>Hours working or in school per week</b>	<b>Days per week S, M, Tu, W, Th, F, S</b>

<b>List your children living in household: First Name, Last Name</b>	<b>Birth Date:</b>	<b>SSN (optional):</b>	<b>Check if child needs care</b>	<b>Indicate which parent(s) are living in household</b>
			<input type="checkbox"/>	<input type="checkbox"/> Mother <input type="checkbox"/> Father
			<input type="checkbox"/>	<input type="checkbox"/> Mother <input type="checkbox"/> Father
			<input type="checkbox"/>	<input type="checkbox"/> Mother <input type="checkbox"/> Father
			<input type="checkbox"/>	<input type="checkbox"/> Mother <input type="checkbox"/> Father
			<input type="checkbox"/>	<input type="checkbox"/> Mother <input type="checkbox"/> Father

<b>INCOME SECTION (Received in previous 30 days)</b>		
Income Source	Monthly Amount	For Whom
Child Support		Verification must be attached Completed Child Support Declaration Form provided
Social Security Supplemental Social Security		Award letter, check stub, or verification from agency
TANF		Award letter, check stub, or verification from agency
Unemployment		Award letter, check stub, or verification from agency
Wages, Salary		Pay stub, or letter from employer w/ EIN number and wage info
Housing Assistance		None
Food Stamps		None
Work Study		None
Other		Attach appropriate documentation
Other		Attach appropriate documentation

I live in \_\_\_\_\_ school district

**Parent/Applicant Statement:**  
 By my signature below, I hereby certify all the information submitted on this document is true and correct to the best of my knowledge. I may be requested to verify these statements and by my signature, give my consent to the agency from where I am requesting information to make any necessary contacts to verify any statement. I understand the information I have provided is private and may not be seen by the public. Further, I understand I may lose my child care if I fail to report a changes to my intake agent within 10 days, if I fail to use my Hoosier Works for Child Care card to electronically document my child(ren)'s attendance, fail to pay my child care provider the required co-payment or fail to utilize my child care for more than 60 days.

Signed, \_\_\_\_\_ Date \_\_\_\_\_

Failure to attach ALL required documentation will result in termination of child care benefits without notice.. (Use application checklist to assist in preparation of worksheet for mailing.)

## CCDF PARENT STATEMENT / RIGHTS AND OBLIGATIONS

I understand the choice of caregiver is not only my choice, it is my responsibility.

I understand it is my responsibility to report any suspected child abuse and neglect to the proper authority and others have the same responsibility concerning my child/children.

I understand parents, step-parents or legal guardians will not be paid as caregivers for their own children.

I understand information concerning my family regarding the CCDF voucher program, and the services I receive, will be treated as confidential and will be used solely for the administration of the CCDF voucher program.

I understand reimbursement for my child's care will be made directly to the provider, unless the care is provided in my home by a non-resident, in which case the payment will be made directly to me. It is my responsibility to reimburse the provider for services rendered as well as any co-payments. I also understand it is my responsibility to withhold and make all applicable Internal Revenue Service (IRS) payments for my child care provider and for the end of the year reporting to the IRS.

I understand it is my responsibility to furnish the Intake Agent with complete and accurate information including, but not limited to, income and family composition. I understand I will be required to submit proof of information provided.

I understand subsidized child care will not begin until all forms are completed and I have received written notice from the Bureau of Child Care or their representative.

I understand I must report to the Intake Agent when my service need ends, my TANF status changes, my family composition changes, I move to a new address or I obtain a new phone number within ten (10) calendar days of the change.

I understand my deliberate failure or misrepresentation of information used to receive services for which I was ineligible will result in a demand for repayment and may also subject me to legal action or penalties.

I understand acceptance or denial of services may not exclude me from eligibility for financial assistance or participation in other programs administered by the Family and Social Service Administration.

I understand my right to file a written complaint if:

- I believe I have been discriminated against because of race, color, age, sex, religion, disability, national origin, or ancestry; or
- My application for services was not promptly acted upon; or
- I disagree with an action taken regarding my eligibility.

I agree to discuss complaints first with my service provider and/or intake agent to resolve the problem through informal means. If the problem is not resolved, I understand the intake agent will provide procedures regarding the appeal process.

I understand I may be asked to cooperate with state and/or federal personnel in any audit or quality assurance review. I further understand my failure to cooperate may result in termination from the program.

I understand I **will** be required to electronically document my child/children's attendance information. I will only utilize my Hoosier Works for Child Care card to document attendance when it truly reflects the care provided.

I understand when signing the service documentation for my child/children's care, I will sign only after the care is provided and if it truly reflects the care provided.

I understand I may not leave my Hoosier Works for Child Care card with my child care provider. I agree to keep my Personal Identification Number (PIN) confidential. I understand failure to comply with this may result in termination of my child care benefits.

I understand my child care may be terminated for any of the following reasons:

- Requesting more than three (3) provider changes in a twelve (12) month period;
- Allowing another person to use my Hoosier Works for Child Care card to document attendance;
- Failing to electronically document my child/children's attendance; and/or
- Failing to pay my co-payment.

I understand my child care will be terminated for any of the following reasons:

- My child is not a U.S. citizen, qualified alien, and/or resident of the county and/or state;
- I fail to complete required CCDF enrollment paperwork;
- I am no longer employed, in a training or education program, or a TANF IMPACT approved activity;
- I have been convicted of welfare fraud;
- My child turns 13 or 18 for a child with documented special needs;
- I deliberately fail to report loss of service need or change in family composition;
- I falsify any required documentation;
- My locally determined subsidy period expires;
- I have been convicted of CCDF fraud;
- I fail to honor a CCDF repayment agreement; and/or
- My child/children's voucher(s) have been inactive for sixty (60) days.

I understand my child care provider may be decertified and child care reimbursement may be suspended or stopped for my child care provider's failure to comply with any of the following provisions:

- A substantiated health or safety hazard;
- Threatening behavior;
- False information on any form connected with the CCDF program;
- Being under investigation for fraud;
- A pending abuse or neglect charge against the provider, existing employee of the provider, or a member of the provider's household if care is provided in the their home;
- The death of a child while in the provider's care; and/or
- Illegally operating a home or facility.

I understand reimbursement will be stopped and my provider will be de-certified for any of the following:

- A conviction or substantiated abuse or neglect charge against the caregiver indicating harmful behavior to children;
- Substantiated fraud in the receipt of government funds;
- Loss of licensure or registration when required by Indiana law;
- Proven forgery of signatures on any forms;
- Failure to comply with CCDF Provider Eligibility Standards as of the effective date of an administrative order; and/or
- Possession or use of Hoosier Works for Child Care cards for the purpose of documenting child/children's attendance.

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Signature of Parent

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Date Signed

# CHILD SUPPORT DECLARATION

I, \_\_\_\_\_ have received an average of \$\_\_\_\_\_ in child support in the previous thirty (30) days for the children listed below.

**Child(ren) Name:**

_____	_____
_____	_____
_____	_____

**By my signature below, I hereby certify all the information provided is true and correct to the best of my knowledge. I understand I may be requested to verify this statement and give my consent to the agency, from where I am requesting services, to make any necessary contacts to verify any statement. I understand my deliberate failure or misrepresentation of any information in this statement may result in my inability to participate in the Child Care Development Fund (CCDF) Voucher Program.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## CCDF NAME ATTESTATION

Individual's Name \_\_\_\_\_  Applicant  Other Adult  Child

*(The name above must exactly match the typed name on the State Form 46513/BCD 0805, Application for Child Care Services)*

is also known as:

\_\_\_\_\_ (Printed Name)

\_\_\_\_\_ (Printed Name)

\_\_\_\_\_ (Printed Name)

and that all names listed above are the same person.

I hereby affirm, under the penalties of perjury, I am the above named individual or the parent/guardian of the above named individual, and I have personally prepared the foregoing statement for myself or my minor child, and that the same is true to the best of my knowledge and belief.

Signature of Individual \_\_\_\_\_ Date \_\_\_\_\_

NOTE: This document shall be used when the individual's names does not match all sources of verification information provided to the Intake Agent.

## STATEMENT OF PROFIT AND LOSS (Self-Employment Form)

Applicant/Other Adult \_\_\_\_\_

Occupation \_\_\_\_\_ Month Reporting \_\_\_\_\_

Instructions: Use the table below to provide a statement of your profit/loss for the previous thirty (30) days. Please provide revenue (money collected for the sale of your goods or service). You may consider any expense considered as such by the Internal Revenue Service (IRS) a legitimate expense for CCDF purposes.

	Revenue	Expense	Profit/Loss
<b>Previous 30 days income:</b>			
<b>Dates</b>			
<b>From:                      To:</b>			
<b>TOTAL REVENUE</b>			
<b>Expense:</b>			
<b>Expense:</b>			
<b>Expense:</b>			
<b>Expense:</b>			
<b>Expense:</b>			
<b>Expense:</b>			
<b>Expense:</b>			
<b>Expense:</b>			
<b>Expense:</b>			
<b>Expense:</b>			
<b>Expense:</b>			
<b>TOTAL EXPENSES</b>			
<b>Profit/Loss (Revenue – Expenses)</b>			

I am requesting \_\_\_\_\_ hours per week of childcare to support my work activity.

By my signature below, I confirm the information provided is a true and accurate representation of my income. I understand I may be asked to provide documentation supporting revenue and expenses and agree to provide this information upon request.

Applicant Signature, \_\_\_\_\_ Date \_\_\_\_\_

**(If there is a co-applicant)**

I am requesting \_\_\_\_\_ hours per week of childcare to support my work activity.

By my signature below, I confirm the information provided is a true and accurate representation of my income. I understand I may be asked to provide documentation supporting revenue and expenses and agree to provide this information upon request.

Co- Applicant Signature, \_\_\_\_\_ Date \_\_\_\_\_



**PROVIDER INFORMATION PAGE (Child Care and Development Fund Voucher Program)**

Parent (Guardian) Name \_\_\_\_\_ Date Completed \_\_\_\_\_

Caregiver's Name \_\_\_\_\_ Business Name (if applicable) \_\_\_\_\_

Street Address (where care is provided) \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Social Security or EIN Number (last 4 digits only) \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Hours of Operation \_\_\_\_\_ Days (Please circle) S M Tu W Th F S

**Type of Provider**

Licensed Home

Licensed Center

Registered Ministry

License Exempt Home

License Exempt Facility

Providing care in child's home

License # \_\_\_\_\_

License # \_\_\_\_\_

Registration # \_\_\_\_\_

Child's Name (first & last)	Child's Age Years / Months	Kindergarten <i>Indicate</i> HD = 1/2 Day FD = Full Day	Current Charge (List charges for School- Age School Year) Week / Day / Hour	Charge for next age group (If child is currently 2 list charge at age 3) Week / Day / Hour	School-age (List charges for summer/evening care) Week / Day / Hour	
						S

**FOR SCHOOL AGE AND KINDERGARTEN FULL-DAY CARE**

School Year Begins \_\_\_\_\_ Ends \_\_\_\_\_

Are you related to the children listed above? \_\_\_\_\_ If yes, explain \_\_\_\_\_

**PLEASE NOTE:** Eligible providers must demonstrate compliance with CCDF Minimum Standards prior to participation in this program.

**Parent / Guardian:** Your caregiver must complete this information in its entirety. Please bring the completed form to your appointment to assist in prompt completion of your child care vouchers. If you wish to make a provider change, you must obtain new vouchers prior to attendance or payment for care may become your responsibility.

**Provider:** Please complete all information and sign the form in the box to the left.

**If you have any questions, please contact Human Services (800) 296-8026**  
P.O. Box 588, Columbus IN 47202-0588

To help find an approved childcare provider, please call:  
Bartholomew & Brown Counties – Childhood Connections @ 1-866-693-0672  
Decatur County – SIEOC @ 1-900-755-8558 or 812-926-1585  
Johnson County – Child Care Answers @ 1-800-272-2937  
Shelby County – Hulifer Memorial @ 1-800-554-9331 or 765-284-0887

**PROVIDER AFFIRMATION**  
I affirm the information provided on this application form is true and correct. Further, I affirm child care will be provided at the address listed above and agree to comply with the rules and regulations of the CCDF program. (Available on BCD website www.in.gov/fssa) In signing this application, I certify I am the individual listed above or the authorized designee.

Signed, \_\_\_\_\_

Date Signed \_\_\_\_\_

# HSI Client Characteristics Survey

1/1/10 thru 12/31/10

Form update 3/31/10

Household Data:

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone ( ) - ( ) - \_\_\_\_\_ Contact Phone \_\_\_\_\_ Email Address (if applicable) \_\_\_\_\_

	Head of Household / Self	List Everyone Living in Household					
<b>First Name:</b>							
<b>Last Name:</b>							
<b>Birth Date:</b>	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
<b>SSN:</b>	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
<b>Gender:</b>	<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Ethnicity:</b>	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Race:</b> <i>(Please select all that apply)</i>	<input type="checkbox"/> White <input type="checkbox"/> Black/African-American <input type="checkbox"/> Amer. Indian/Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Multi-Race (2 or more above)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Highest Level of School Completed/Post Secondary Degree</b>	<input type="checkbox"/> No School <input type="checkbox"/> Nursery School – 4 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> Grade – 6 <sup>th</sup> Grade <input type="checkbox"/> 7 <sup>th</sup> Grade – 8 <sup>th</sup> Grade <input type="checkbox"/> 9 <sup>th</sup> Grade <input type="checkbox"/> 10 <sup>th</sup> Grade <input type="checkbox"/> 11 <sup>th</sup> Grade <input type="checkbox"/> 12 <sup>th</sup> Grade – No Diploma <input type="checkbox"/> 12 <sup>th</sup> Grade – High School Diploma <input type="checkbox"/> GED <input type="checkbox"/> Associate Degree (2 year) <input type="checkbox"/> Bachelors Degree (4 year) <input type="checkbox"/> Masters Degree <input type="checkbox"/> Doctorate <input type="checkbox"/> Other Graduate/Profession Degree	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Relationship to Head of Household:</b>	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Adult Child <input type="checkbox"/> Sibling <input type="checkbox"/> Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Friend <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Other:</b>	<input type="checkbox"/> Have no health insurance <input type="checkbox"/> Disabled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Housing:</b>	<input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Literally Homeless <input type="checkbox"/> Housed – loosing housing <input type="checkbox"/> Housed – at risk of losing housing <input type="checkbox"/> Other:	Move in date for home/apartment (approximate): ____/____/____ (month/date/year required) If other, please list: _____					

Circle one in each category or fill in the blanks as requested:

Are you enrolled in Life Line Link-up? Yes or No (circle one)  
 Would you like information on the Life Line Link-up program? Yes or No (circle one)

**Family Type:** Single Parent (Female or Male) / Two Parent / Single Person / Two Adults/No Children / Other: \_\_\_\_\_

**Source of Family MONTHLY Income:** (Please list the amount for each category. If no income exists, please check the box below)

No current source of income

Earned Income:	\$	Unemployment Benefits:	\$	Social Security Income (survivors' benefits):	\$
Social Security Disability Income:	\$	Veteran's Disability Pay:	\$	Private Disability Insurance:	\$
Workers' Compensation:	\$	TANF:	\$	General Public Assistance:	\$
Social Security from Retirement:	\$	Veteran's Pension:	\$	Pension from a former job:	\$
Child Support:	\$	Alimony or spousal support:	\$	Other:	\$

**Non-Cash Benefits:** (Please check all that apply)

<input type="checkbox"/>	Food Stamps or money for food	<input type="checkbox"/>	Medicaid health insurance program
<input type="checkbox"/>	Medicare health insurance program	<input type="checkbox"/>	Healthy Indiana Plan ( <i>Hoosier Healthwise</i> )
<input type="checkbox"/>	Women, Infants and Children ( <i>WIC</i> )	<input type="checkbox"/>	Veteran's Administration ( <i>VA Medical Services</i> )
<input type="checkbox"/>	TANF Child Care Vouchers	<input type="checkbox"/>	TANF Transportation Services
<input type="checkbox"/>	Other TANF-funded services	<input type="checkbox"/>	Private Health Insurance
<input type="checkbox"/>	Section 8, public housing, other rental assistance	<input type="checkbox"/>	Other Health Insurance
<input type="checkbox"/>	Other (specify):	<input type="checkbox"/>	None of the above

**For Staff Use Only:**

**County:**  Bartholomew  Brown  Decatur  Jackson  Johnson  Shelby

**Programs:** \_\_\_ Food Pantry \_\_\_ Head Start \_\_\_ Section 8 \_\_\_ WIC \_\_\_ Weatherization \_\_\_ Childcare Scholarship  
 \_\_\_ CCDF \_\_\_ EF & SP \_\_\_ EAP \_\_\_ Safety Net \_\_\_ Salvation Army  
 \_\_\_ Transitional Support Svcs \_\_\_ Transitional Shelter \_\_\_ Emergency Shelter \_\_\_ Wheels to Work  
 \_\_\_ Continuum of Care \_\_\_ CSBG: \_\_\_\_\_

**ARRA Funded Project:** Yes or No (please circle one) **What program above is ARRA funded?** \_\_\_\_\_

Staff Person completing form: \_\_\_\_\_ (first initial, last name)

Admission Date: \_\_\_\_\_

Discharge Date: \_\_\_\_\_ (required for data entry)