

# ADMISSION INFORMATION

|   |                        |   |                            |
|---|------------------------|---|----------------------------|
| Operation Name<br><b>Braswell Child Development</b>   |                        | Director's Name<br><b>M.Webb</b>            |                            |
| Child's Full Name   |                        | Child's Date of Birth                       | Child's Home Telephone No. |
| Child's Home Address  |                        |   |                            |
| Date of Admission   | Date of Withdrawal     |   |                            |
| Parent's or Guardian's Name   |                        | Address (if different from child's address) |                            |
| List telephone numbers below where parents/guardian may be reached while child will be in care:   |                        |   |                            |
| Mother's Telephone No.  | Father's Telephone No. | Guardian's Telephone No.                    | Cell Phone No              |
| Give the name, address and phone number of person to call in case of an emergency if parents / guardian cannot be reached:  |                        |   | Relationship               |
| I hereby authorize the childcare operation to allow my child to leave the childcare operation ONLY with the following persons. Please list name & telephone number for each. Children will only be released to a parent or a person designated by the parent/guardian after verification of ID. |                        |   |                            |

Drivers License Number \_\_\_\_\_ Social Security Number \_\_\_\_\_

|  |  |  |  |
|--|--|--|--|
| <b>CHECK ALL THAT APPLY:</b> I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give – consent for my child to be transported and supervised by the operation's employees:   |  |  |  |
| 1. <input type="checkbox"/> <b>TRANSPORTATION:</b><br>Walk home <input type="checkbox"/> for emergency care <input type="checkbox"/> on field trips <input type="checkbox"/> to and from home <input type="checkbox"/> to and from school  |  |  |  |
| 2. <input type="checkbox"/> <b>FIELD TRIPS:</b> I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give – my consent for my child to participate in Field Trips:<br>Parent's Comments:   |  |  |  |
| 3. <input type="checkbox"/> <b>WATER ACTIVITIES:</b> I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give – my consent for my child to participate in Water Activities:<br><input type="checkbox"/> sprinkler play <input type="checkbox"/> splashing/wading pools <input type="checkbox"/> swimming pools <input type="checkbox"/> water table play                                |  |  |  |
| 4. <input type="checkbox"/> <b>RECEIPT OF WRITTEN OPERATIONAL POLICIES:</b><br>I acknowledge receipt of the facility's operational policies including those for discipline and guidance.   |  |  |  |
| 5. I UNDERSTAND THAT THE FOLLOWING MEALS WILL BE SERVED TO MY CHILD WHILE IN CARE:<br><input type="checkbox"/> None <input type="checkbox"/> Breakfast <input type="checkbox"/> AM Snack <input type="checkbox"/> Lunch <input type="checkbox"/> PM Snack <input type="checkbox"/> Supper <input type="checkbox"/> Evening Snack   |  |  |  |
| 6. MY CHILD IS NORMALLY IN CARE ON THE FOLLOWING DAYS AND TIMES:<br><input type="checkbox"/> Mondays from: to:<br><input type="checkbox"/> Tuesdays from: to:<br><input type="checkbox"/> Wednesdays from: to:<br><input type="checkbox"/> Thursdays from: to:<br><input type="checkbox"/> Fridays from: to:<br><input type="checkbox"/> Saturdays from: to:<br><input type="checkbox"/> Sundays from: to: |  |  |  |

|  |          |       |
|--|----------|-------|
| <b>AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:</b><br>In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to: |          |       |
| Name of Physician:   | Address: | Ph.#: |
| Name of Emergency Medical Care Facility:   | Address: | Ph.#: |
| I give consent for the facility to secure any and all necessary emergency medical care for my child.   |          |       |
| _____<br>Signature - Parent or Legal Guardian  |          |       |

List any special problems that your child may have, such as allergies, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information which caregiver's should be aware of:

Child daycare operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800)-514-0383 (TTY).

Signature – Parent or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Full time Part Time Part time Schoolage w/summer      \*\*Braswell CDC is a nonprofit 501©3 entity and does not discriminate  
Regardless of race, origin, religion, creed, ethnic origin ( Revised 2014)

Child's Name : \_\_\_\_\_

Parents Name: (print) \_\_\_\_\_ Signature: \_\_\_\_\_

## POLICIES Revised 2018

### Hours and Fees

- **The center operates from 6:00a.m.-6:00p.m.** The late fee is \$1.00 per minute per child. Late fees are due regardless of the reason for being late.
- **We do not accept children after 9:00a.m.**  
Tuition is due in advance and must be paid no later than Tuesday. **CCMS monthly payments are due the first week of the month.** **Late payments are \$30.00.** Money orders and cash accepted.
- Programs are available to the person who qualifies such as CCMS/CCA, City of Dallas Program, CCAP, TWC, etc. You may contact these agencies at your convenience.
- **Tuition is due on a weekly basis.** We do not deduct for days missed due to illness, holidays, bad weather or parent's day off. Tuition fees are non-refundable. Upon enrollment, a place in center has been reserved for your child, therefore **drop-ins** are welcome if there are any spaces available at the rate of **\$50.00 per child.**
- Enrollment fee is 50.00 payable upon enrollment, payment is non-refundable and **expires within 2weeks.**
- **We do not accept checks.**

### Supply Fees

You will receive a notice in your child's bag or delivered by an adult, when your supplies have depleted i.e., diapers, wipes, formula, extra clothes, baby food. **If you do not bring supplies** the next day, your choices are as follow:

**Bring supplies by 12:00p.m. — Pay a \$10.00 supply fee**

### Transportation

#### Pick-up from home

**Van route starts at 6:15a.m. ending at 7:30a.m.**

If your children are not ready to be picked up, we encourage you to bring them in **before 9:00a.m.** Pick-up address must be the same in application package

#### Drop-off home

**Van route starts at 4:00p.m. ending at 5:00p.m.**

If no one is available to receive children The children will be brought back to the center, where they must be picked up before 6:00p.m. (person must be on application),

**(\*\*Refer to hours and fees for after 6:00p.m. penalties)** Drop off address must be the same in application package.

**The center will be closed on the following holidays:** (holidays are subject to change please check with center prior to)

Jan.-Martin L. King Birthday

March/April-Good Friday

May-Memorial Day

July-Fourth f July

Sept-Labor Day

New Years Day

Nov.-Thanksgiving Day and day after

Dec.-Christmas Day and day after

### Illness

Any child showing symptoms of illness will be isolated and a parent will be notified. Please do not bring sick child to the center. In the event the vision and hearing screening conflicts with church, religious or denomination practices, a notarized statement must be submitted to the center to be placed in the personnel file of the child in question

## **DISCIPLINE**

Our methods of discipline are as follows:

A teacher tries to use a positive and firm approach to guide the child into an acceptable behavior at all times. Separation from the group anything that requires a bit of quiet time. Sitting in a chair not participating in group activities for anything such as hitting, excessive roughness, or at teacher's discretion. Hostile behavior endangers the safety of other children or demands the complete attention of the caregiver

All disciplinary measures given to the children in our care will be fair and equitable to both children and teacher, while teaching good behavior and consideration of the rights of others and the teacher's right to enforce order in the classroom.

## **PARENTS COMMUNICATION**

All parents have the right to request a parent conference with the supervisor of staff. If concern or complaints have not been satisfied you have the right to speak to the director. We have an open door policy and invite your visit, concerns, complaints and compliments.

## **PLEASE BRING UPDATED SHOT RECORDS HEALTH AND SAFETY**

We ask that each child dress comfortable for activities as well as provide us with a change of clothing. Please be reminded, we learn through play and are concerned with your child's well being. Do not send expensive bows, jewelry, etc., or dress them in expensive clothing. Children work extremely hard each day and should be concerned with the fun learning while at play rather than keeping sparkling clean.

**All accidents will be accompanied by an accident report. If severe, parents are notified via phone. Shot records and doctor's statement are required upon enrollment.**

Children released from the center must be accompanied by an adult or have a written statement on file.

Given permission from them to leave the center IDENTIFICATION IS REQUIRED.

The center reserves the right to ask a parent to remove their child for any of the following reasons:

1. Diseases or problems that would endanger the health or well being of others
2. Unclean or uncared for child-Child Protective Services will be notified.
3. Unreasonable demands by parents for special treatments of child by the teacher or director.
4. Parents does not pay child care tuition as stated in advance
5. Late pick up for child violating policies

**I HAVE READ AND ACCEPT THE POLICIES OF THE FACILITY AND HAVE BEEN GIVEN A COPY FOR REFERENCE.**

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

Discipline and Guidance Policy for \_\_\_\_\_  
Name of Operation

**Discipline must be:**

- (1) Individual and consistent for each child;
  - (2) Appropriate to the child's level of understanding ; and
  - (3) Directed toward teaching the child acceptable behavior and self-control.
- A caregiver may only use positive methods of discipline and guidance that encourage self-esteem, self-control, and self-direction, which include at least the following :
    - (1) Using praise and encouragement of good behavior instead of focusing only upon unacceptable behavior;
    - (2) Reminding a child of behavior expectations daily by using clear, positive statements;
    - (3) Redirecting behavior using positive statements; and
    - (4) Using brief supervised separation or time out from the group, when appropriate for the child's age and development, which is limited to no more than one minute per year of the child's age.
  - There must be no harsh, cruel, or unusual treatment of any child. The following types of discipline and guidance are prohibited:
    - (1) Corporal punishment or threats of corporal punishment;
    - (2) Punishment associated with food, naps, or toilet training;
    - (3) Pinching, shaking, or biting a child;
    - (4) Hitting child with a hand or instrument;
    - (5) Putting anything in or on a child's mouth;
    - (6) Humiliating, ridiculing, rejecting, or yelling at a child;
    - (7) Subjecting a child to harsh, abusive, or profane language;
    - (8) Placing a child in a locked or dark room, bathroom, or closet with door closed; and
    - (9) Requiring a child to remain silent or inactive for inappropriately long time for the child's age.

My signature verifies I have read and received a copy of this discipline and guidance policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Check one please:

Parent / Guardian  Employee/caregiver  Household member of a child care home

To Whom It May Concern:

This is to certify that immunization and annual medical records for

\_\_\_\_\_ Childs Name

Are on file at:

PLEASE CIRCLE SCHOOL THAT YOU CHILD ATTENDS:

**Paul L. Dunbar**  
4200 Metropolitan  
972-794-6600  
972-749-6601

Room# \_\_\_\_\_  
Teacher's Name \_\_\_\_\_

**Martin Luther King Learning Center**  
1817 Warren Ave  
972-502-8100

Room # \_\_\_\_\_  
Teacher,s Name \_\_\_\_\_

**J.J. Rhoads**  
4401 2<sup>nd</sup> Ave  
972-749-1000  
972-749-1001

Room# \_\_\_\_\_  
Teacher's Name \_\_\_\_\_

**H. S. Thompson**  
5700 Bexar St  
972-749-1700

Room# \_\_\_\_\_  
Teacher's Name \_\_\_\_\_

**If we do not have the school listed please fill in the info on the lines:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Parent Signature

\_\_\_\_\_ Date



\_\_\_\_\_ has been examined  
Childs name  
by a physician within the year and is able to participate in the  
child care activities.

Physician \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_  
\_\_\_\_\_

Doctor's Signature \_\_\_\_\_

Date \_\_\_\_\_  
\_\_\_\_\_

Braswell Child Development !  
Child Development Center .  
2203 Second Avenue  
Dallas, Texas 75210  
214-565-0300  
214-565-0301Fax

Kids Concepts  
Child Development Center  
4019 W. Ledbetter  
Dallas Texas 75233 Dallas,  
214-351-8808

Child/Children's Name

Emergency Numbers

Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Hospital \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Guardian Name: \_\_\_\_\_

Emergency Contact #'s

Contact 1: \_\_\_\_\_

Contact #: \_\_\_\_\_

Contact 2: \_\_\_\_\_

Contact #: \_\_\_\_\_

Contact 3: \_\_\_\_\_

Contact #: \_\_\_\_\_

\_\_\_\_\_  
*Parent or Guardian Signature*

# Minor Release

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In consideration of the engagement as a model of the minor named below, and for other good and valuable consideration herein acknowledged as received, upon the terms hereinafter stated, I hereby grant SPIDA, INC. A.A. Braswell CDC, Kids Concepts Inc. ("Photographer"), his/her legal representatives and assigns, those for whom Photographer is acting, and those acting with his/her authority and permission, the absolute right and permission to copyright and use, re-use, publish, and republish photographic portraits or pictures of character or form, without restriction as to changes or alterations from time to time, in conjunction with the minor's own or a fictitious name, or reproductions thereof in color or otherwise, made through any medium at his/her studios or elsewhere, and in any and all media now or hereafter known, for art, advertising trade or any other purpose whatsoever. I also consent to the use of any printed matter in conjunction therewith.

I hereby waive any right that I or the minor may have to inspect or approve the finished product or products or the advertising copy or printed matter that may be used in connection therewith or the use to which it may be applied.

I hereby release, discharge and agree to save harmless Photographer, his/her legal representatives or assigns, and all persons acting under his/her permission or authority or those for whom he/she is acting, from any liability by virtue of any blurring, distortion, alteration, optical illusion, or use in composite form, whether intentional or otherwise, that may occur or be produced in the taking of said picture or in any claims for libel or invasion of privacy.

I hereby warrant that I am of full age and have every right to contract for the minor in the above regard. I state further that I have read the above authorization, release, and agreement, prior to its execution, and that I am fully familiar with the contents thereof. This release shall be binding upon me and my heirs, legal representatives, and assigns.

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DATE

---

(WITNESS)

---

(MINOR'S NAME)

---

(ADDRESS)

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(FATHER)(MOTHER)(GUARDIAN)

\_\_\_\_\_ Yes, I give permission    \_\_\_\_\_ No, permission is not given

In consideration of being allowed to participate in any parties or programs with the facility (**A.A. Braswell, Or Kids Concepts**) the undersigned, on his or her own behalf and on behalf of the minor identified below, acknowledges, appreciates and agrees that:

I willingly agree to comply with the stated and customary terms, rules and conditions of participation. In addition, if I observe any hazard during my participation, I will bring it to the attention of the nearest official immediately; and

There is a risk of injury from this equipment, and while particular rules, equipment and personal discipline reduce the risk, the risk does exist; and

I knowingly and freely assume all such risks both known and unknown, even if arising from the negligence of other participants listed below. Further, I agree to assume liability for all medical costs, attorney's fees, and all other damages resulting from injury to myself and the undersigned participants; and

I for myself and on behalf of my heirs, assigns, personal representatives and next of kin, hereby hold harmless Spida Inc., d/b/a **Kids Concepts, A.A. Braswell in Dallas, TX** and other affiliates, officers, members, agents, and employees and other participants with respect to any and all injury, disability, or loss or damage to person or property to the fullest extent of the law; and

By signing below for myself, my children and/or my spouse, I agree to the above conditions.

Participant Name: \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_ City/Zip \_\_\_\_\_

Adult/Guardian Signature (PLEASE PRINT): \_\_\_\_\_

Adult/Guardian Signature: \_\_\_\_\_

Emergency Contact Phone #'s: \_\_\_\_\_ / \_\_\_\_\_

Name of event and date: \_\_\_\_\_



**EXPULSION POLICY**

Unfortunately, there are sometimes we have to expel a child from our program either on a short term or permanent basis. WE want you know that we will do everything possible to work with the family of the child (ren) in order to prevent this policy from being enforced. The following reasons we may have to expel or suspend a child from Braswell:

**Immediate Causes for Expulsions:**

The child is at risk of causing serious injury to other children or him/herself  
Parent threatens physical or intimidating action towards staff members.

**Parent Actions for Child's Expulsion**

Failure to pay/habitual lateness in payments  
Failure to complete required forms including the child's immunization records  
Habitual tardiness when picking up your child/children/  
Verbal abuse to staff.

**Child's Actions for Expulsion**

Failure of child to adjust after a reasonable amount of time  
Uncontrolled tantrums/angry outbursts  
Ongoing physical or verbal abuse to staff or other children  
Excessive biting

Prior to expulsion, a parent will be called and correspondence will be sent home indicating what the problem is, and every effort will be made by both the center and the parent to correct the problem. If, after one or two weeks, depending on the risk of the other children's safety. The parent will be asked to remove him/her.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Child(ren)



# CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

### Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:

- Hispanic or Latino
- Not Hispanic or Latino

Mark one or more racial identities:

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

### Part 7. Sharing Information With Other Programs: OPTIONAL

The above information may be disclosed for the purpose of enrolling children in the Children's Health Insurance Program (CHIP). Parents/guardians are not required to consent to such disclosure and electing not to allow disclosure will not adversely affect a child's eligibility.

- I **do** elect to allow my household information to be disclosed.
- I **do not** elect to allow my household information to be disclosed.

### Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: \_\_\_\_\_ Per:  Week,  Every 2 Weeks,  Twice A Month,  Month,  Year Household size: \_\_\_\_\_

Categorical Eligibility: \_\_\_ Date Withdrawn: \_\_\_\_\_ Eligibility: Free\_\_\_ Reduced\_\_\_ Denied\_\_\_ Tier I\_\_\_ Tier II\_\_\_

Reason: \_\_\_\_\_

Determining Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Confirming Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Follow-up Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Privacy Act Statement:

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 the participant for free or reduced price meals. You must include the last four digits of 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 (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) eligibility number for the participant or other (FDPIR) identifier 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 the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

### Non-discrimination Statement:

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

- (1) mail: U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410; or
- (2) fax: (833) 256-1665 or (202) 690-7442; or (3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

This institution is an equal opportunity provider.



# CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

## Part 1. All Household Members

Name of Enrolled Child(ren):

| Names of all household members<br>(First, Middle Initial, Last) | CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT)<br>* IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM. | CHECK IF NO INCOME       |
|---|--|--------------------------|
|   | <input type="checkbox"/>   | <input type="checkbox"/> |

**Part 2. Benefits:** If any member of your household receives SNAP, TANF, or FDIPIR, provide the name and eligibility number for the person who receives benefits. If no one receives these benefits, skip to part 3.

NAME: \_\_\_\_\_ ELIGIBILITY NUMBER: \_\_\_\_\_

**Part 3. (Applies only to parents/guardians with children enrolled in a day care home)** If any member of your household receives benefits listed on the enclosed *List of Eligible Federal/State Funded Programs (H1660)*, provide the name of the program and eligibility number: NAME: \_\_\_\_\_ ELIGIBILITY NUMBER: \_\_\_\_\_

Check here if no eligibility number

## Part 4. Total Household Gross Income—You must tell us how much and how often

| A. Name<br>(List only household members with income) | B. Gross income and how often it was received             |                                    |  |                     |
|--|---|------------------------------------|--|---------------------|
|  | Note: Self-employed report income after expenses in box 1 |                                    |  |                     |
| (Example)<br>Jane Smith                              | 1. Earnings from work before deductions                   | 2. Welfare, child support, alimony | 3. Pensions, retirement, Social Security, SSI, VA benefits | 4. All Other Income |
|  | \$200/weekly  | \$150/twice a month                | \$100/monthly  | \$200/bi-monthly    |
|  | \$ ___/___  | \$ ___/___                         | \$ ___/___   | \$ ___/___          |
|  | \$ ___/___  | \$ ___/___                         | \$ ___/___   | \$ ___/___          |
|  | \$ ___/___  | \$ ___/___                         | \$ ___/___   | \$ ___/___          |
|  | \$ ___/___  | \$ ___/___                         | \$ ___/___   | \$ ___/___          |
|  | \$ ___/___  | \$ ___/___                         | \$ ___/___   | \$ ___/___          |

## Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the next page.)

*I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.*

Sign here: \_\_\_\_\_ Print name: \_\_\_\_\_

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

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Last four digits of Social Security Number: \* \* \* - \* \* - \_\_\_\_\_  I do not have a Social Security Number