

Privacy Act Statement (PAS)

Authorities – This information is requested pursuant to the National and Community Service Act of 1990 as amended (42 USC 12501 *et seq.*), the Domestic Volunteer Service Act of 1973 as amended (42 USC 4950 *et seq.*), and E.O. 9397 as amended. **Purposes** – It is requested to manage, administer, and evaluate the childcare benefits program offered to eligible AmeriCorps Service Members. **Routine Uses** – Routine uses of this information may include disclosure to (1) contractors to assist with administering the childcare benefit, (2) individuals and organizations providing childcare, and (3) federal, state, or local agencies pursuant to lawfully authorized requests. A complete list of uses can be found in the system of records notice associated with this collection of information, [CNCS-06-CPO-ACB-AmeriCorps Childcare Benefit System \(ACB\)](#). **Effects of Nondisclosure** – This request is voluntary, but not providing the information will likely affect your ability to receive childcare benefits.

AMERICORPS MEMBER AND SUPERVISOR INFORMATION

AmeriCorps Member Name	
AmeriCorps Site Supervisor Name	
Supervisor's Email Address	
Supervisor's Telephone #	

SERVICE ASSIGNMENT PROGRAM INFORMATION

Service Assignment Program Name:		
Service Site Address:		
Street:		
City:	State:	Zip Code:
<p>Program Affiliation: Which of the following programs is the AmeriCorps Member enrolled in? Please check one of the three programs below:</p> <p><input type="checkbox"/> AmeriCorps State and National (if checked, is the Member serving in the Professional Corps Program?) Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><input type="checkbox"/> AmeriCorps VISTA</p> <p><input type="checkbox"/> AmeriCorps NCCC/FEMA</p>		
<p>Please check the slot type the AmeriCorps Member signed up to work:</p> <p><input type="checkbox"/> Regular Full Time (1700 Hours of) Service.</p> <p><input type="checkbox"/> Half-time, Reduced Half-time, or Quarter Time.</p> <p>If the AmeriCorps Member is not a full time associate, in what capacity is the AmeriCorps Member serving?</p> <p><input type="checkbox"/> Full Time Capacity</p> <p><input type="checkbox"/> Part Time Capacity</p>		
Service Term Start Date:	Projected Term End Date:	
____/____/____	____/____/____	

Will the member be required to complete service hours during the weekend? (*Verification of weekend service hours will be needed)

Yes No Other* (occasionally)

AMERICORPS PROGRAM DIRECTOR CERTIFICATION

I certify that the Member listed above is eligible to receive child care benefits, and I certify and affirm the following:

- ✓ I have confirmed the Member is currently an active AmeriCorps/Vista/NCCC Member.
- ✓ The Member will need child care services in order to serve with in this program.
- ✓ I certify that I will formally notify GAP Solutions in writing within five (5) business days if the Member has any interruption of their service, they end their service term early or of any other status changes that may affect the member's eligibility for child care benefits.

AmeriCorps Program Director Name
(please print)

AmeriCorps Program Director Signature

Date