CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child

Clear Form

Part I. All Household Members

Name of Enrolled Child(ren)

Name of all household members (First, Middle, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE A FOSTER CHILDREN SKIP TO PART 5 TO SIGN THIS FORM	CHECK IF NO INCOME
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Part 2. Benefits: If any member of your household receives SNAP, TANF, or FDPIR., 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 case number ☐

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

A. Name (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			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All other income
(Example) Jane Smith	$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"

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Part 6. Participant's ethnic and racial identities (0ptional)	
Mark one ethnic identity:	Mark one or more racial identities:
☐ Hispanic or Latino ☐ Not Hispanic or Latino	☐ Asian ☐ American Indian or Alaska Native ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American

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 Officer's Signature _____ Date: _____

Confirming Officer'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, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339 Additionally, program information may be made available in languages other than English

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992 Submit your completed form or letter to USDA by·

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Right
1400 Independence Avenue, SW
Washington, D.C. 20250-9410,
This institution is an equal opportunity provider.

(2) fax: *(202)* 690-7442, or (3) email: program intake@usda.gov

NEW ☐ **UPDATE** ☐ **DROP IN** ☐

Institution Name: CHILD CARE PLUS_____ Agreement Number: _CE ID 02051_____

Facility/Provider Name: _A B C Academy, LLC 1326_____

Child and Adult Care Food Program (CACFP)
Participant Enrollment Form

Your day care facility participates in the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). The enrolled participant will receive nutritious meals and snacks at no cost to you. CACFP needs verification of enrollment for each participant in this facility. Please fill out the parent/guardian section of this form, sign it and return it to the above facility/provider. Provide information for one participant per section. **(In order for the institution to receive reimbursement for meals served/claimed, this form must be completed for each enrolled participant annually.)**

Parent/Guardian Please Complete

Participant's (Child) Name: _____ Date of Birth _____ Age _____

Sex ☐ Male ☐ Female Date participant enrolled in the facility _____

Food Allergies: ☐ Yes ☐ No If "yes" specify: _____

(If the participant cannot be served the CACFP Meal Pattern, a statement from the participants Health Care Provider must be provided)

Check days of Normal Care at facility ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Check meals normally eaten at facility ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

Please list the normal times of arrival and departure (check am or pm) **Arrive:** _____ ☐ am ☐ pm **Depart: :** _____ ☐ am ☐ pm

RACE OF PARTICIPANT: You are NOT required to answer this question.

☐ White ☐ Black or African American ☐ American Indian/Alaska Native

☐ Asian ☐ Native Hawaiian or Other Pacific Islander

ETHNIC IDENTITY: You are NOT required to answer this question.

☐ Hispanic or Latino ☐ Not Hispanic or Latino

If participant is an infant (0 to 11months), please complete this box, Check all applicable choice(s) below:

This institution/facility offers _____ formulas for infants through CACFP. It is your choice whether or not to use this formula based on your infants needs. Baby foods provided by the institution/facility must be in compliance with the infant meal pattern as required by 7CFR 226 20.

Please mark your preference (choose all that apply)	Today's Date / Birth – 5 months	Today's Date / 6 – 11 months
I will bring expressed breast milk for my infant.	☐	☐
I want the provider to provide the infant formula for my infant.	☐	☐
I will bring the infant formula for my infant Please list the kind of infant formula you will bring		

According to CACFP requirements in order to claim meals for reimbursement, the provider must provide the infant cereal and other food when your infant is developmentally ready to accept them.

Please mark your preference	Today's Date / 6 – 11 months
I want the provider to provide the infant cereal and other foods for my infant	☐
I will bring the infant cereal and/or other foods for my infant	☐

Note to parents who are getting formula through WIC program: Your baby is eligible to get formula from this child care institution/facility as well as from the WIC Program. It is your decision which formulas you want your baby to use when she/he is at child care. If you find you are getting more formula than your baby needs, you may wish to talk to your WIC nutritionist or your child care provider.

I hereby certify the information given on this sheet is true and correct to the best of my knowledge. I also certify that I was given CACPF Meal Benefits Income Eligibility Form Letter to Household, the WIC information, Building for the Future Flyers, Civil Rights Appeals Procedures.

Parent/Guardian Signature: _____ Date: _____

Print Name: _____

Address: _____ City _____ State: _____ Zip Code: _____

Home Telephone Number: _____ Date Dropped

Work Telephone Number: _____ Emergency Telephone Number: _____ _____