

NEW  UPDATE  DROP IN

Institution Name: Creating Tasty Choices Food Program Agreement Number: 101-0664

Facility/Provider Name: ABC & 123 Childcare 1001

**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 participant's Health Care Provider must be**

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  America 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 (0-11 months), please complete this box, Check all applicable choice(s) below:**

This institution/facility offers \_\_\_\_\_ formula for infants through CACFP. It is your choice  
(To be completed by facility/provider)  
whether or not to use this formula based on your infant's 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	Today's Date	Today's Date
	Birth - 3 months	4 - 7 months	8 - 11 months
I will bring expressed breastmilk 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 infant cereal and other foods when your infant is developmentally ready to accept them.	Today's Date	Today's Date
	4 - 7 months	8 - 11 months
	Please mark your preference	
I want the provider to provide the infant cereal and other foods for my		
I will bring the infant cereal and/or other foods for my infant.		

*Note to parents who are getting formula through the 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 formula 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 with 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 CACFP 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: \_\_\_\_\_

In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA Director Office of Adjudication and Compliance, 1400 Independence Avenue SW, Washington, DC 20250-9401 or call (866) 632-9992, (202) 260-1026 or (202) 401-0216 (TDD). This institution is an equal opportunity provider and employer.



## CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

### Part 1. All Household Members

Name of Enrolled Child(ren):

Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * 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"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

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

NAME: \_\_\_\_\_ CASE 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 case number:

NAME: \_\_\_\_\_ CASE NUMBER: \_\_\_\_\_

Check here if no case number

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

<b>A. Name</b> (List <b>only</b> household members with income) <i>(Example)</i> Jane Smith	<b>B. Gross income and how often it was received</b>			
	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



## CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

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

Mark one ethnic identity:	Mark one or more racial identities:	
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian or Alaska Native
<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
	<input type="checkbox"/> 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 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) case 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:

The U.S Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](http://www.ascr.usda.gov/complaint_filing_cust.html), found online at [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at [program.intake@usda.gov](mailto:program.intake@usda.gov).

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

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