

Child and Adult Care Food Program (CACFP)

I have received the following CACFP Documents:

- ☐ CACFP Letter to Households
- ☐ Enrollment Form (Must be entirely filled out by parents)
- ☐ WIC Guidelines
- ☐ Building for the Future Flyer

Child(ren) Name(s)

Parent Name

Parent Signature

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled at [Name of Center]. This center offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP reimburses centers for healthy meals and snacks served to children enrolled in child care based on their eligibility for free or reduced-price meals. Higher reimbursement is received for meals served to enrolled participants who are eligible for free or reduced-price meals, and this reimbursement is then used to purchase healthy food to prepare nutritious meals. Please help us comply with the requirements of the CACFP by completing the attached Meal Benefit Income Eligibility Form so that we can determine your child(ren)'s eligibility for free or reduced-price meals.

1. Am I required to complete a Meal Benefit Income Eligibility Form in order to receive meals? No, but if you choose to do so, this center may receive a higher reimbursement for the meals you receive, which is used to buy nutritious food for meals.

2. Do I need to fill out a Meal Benefit Form for each of my children in day care? If all children enrolled for care at this center live in the same home, you only need to complete and submit one CACFP Meal Benefit Income Eligibility Form for these children. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. **Return the completed form to: [(Name of Center, address, phone number)].**

3. Who is eligible for free or reduced-price meals? While this center does not charge for meals served, children in households receiving benefits in the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR); foster children (reference question #7 for more information on foster children); or children designated as homeless are automatically eligible for free meals, and no additional income information needs to be provided.

Children enrolled in a Head Start Program (HSP), Early Head Start Program (EHSP), or Even Start Program (ESP) (must not have yet entered kindergarten) are also eligible for free meals. Households with children enrolled in an HSP, EHSP, or ESP can provide a certification letter from the program of the child's enrollment and do not need to complete the CACFP Meal Benefit Income Eligibility Form. **Note that only the child or children enrolled in these programs will qualify for benefits.**

All other children living in households with a combined income that does not exceed the household income thresholds attached to this letter and as documented on the Meal Benefit Income Eligibility Form are eligible for reduced-price meals and may be eligible for free meals based on the determination of this center.

4. Who should I include as members of my household? You must include everyone in your household (such as grandparents, other relatives, or friends who live with you) who shares income and expenses. You must include yourself and all children who live with you, including foster children or homeless children who temporarily live with you.

5. How do I report income information and changes in employment status? The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income Chart, the center will receive a higher level of reimbursement. Once properly approved for free or reduced-price benefits, whether through income, providing a current SNAP, TANF, FDPIR case number, or by providing a certification letter establishing participation in an HSP, EHSP, or ESP, your child will remain eligible for those benefits for 12 full months. You should notify us, however, if you or someone in your household becomes unemployed, and the loss of income causes your household income to be within the eligibility standards.

6. What if my income is not always the same? List the amount that you normally get. For example, if you normally get \$1000 each month, but you missed some work last month and only got \$900, put down that you get \$1000 per month. If you normally get overtime, include it, but not if you only get it sometimes.

7. What if I have foster children? Foster children who are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the Meal Benefit Form but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children can provide the Texas Department of Family and Protective Services Form 2085FC, *Placement Authorization Foster Care/Residential Care*, to their child's caregiver and do not need to complete the CACFP Meal Benefit Income Eligibility Form.

8. We are in the military, do we include our housing and supplemental allowances as income? If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex, age or disability.

If you have other questions or need help, call [281-325-0365].

Sincerely,

[signature]

Effective July 1, 2026 – June 30, 2027

Household Size	Total Income									
	Annual		Monthly		Twice-Monthly		Bi-Weekly		Weekly	
No. of Household Members	Free	Reduced	Free	Reduced	Free	Reduced	Free	Reduced	Free	Reduced
1	\$20,748	\$29,526	\$1,729	\$2,461	\$865	\$1,231	\$798	\$1,136	\$399	\$568
2	\$28,132	\$40,034	\$2,345	\$3,337	\$1,173	\$1,669	\$1,082	\$1,540	\$541	\$770
3	\$35,516	\$50,542	\$2,960	\$4,212	\$1,480	\$2,106	\$1,366	\$1,944	\$683	\$972
4	\$42,900	\$61,050	\$3,575	\$5,088	\$1,788	\$2,544	\$1,650	\$2,349	\$825	\$1,175
5	\$50,284	\$71,558	\$4,191	\$5,964	\$2,096	\$2,982	\$1,934	\$2,753	\$967	\$1,377
6	\$57,668	\$82,066	\$4,806	\$6,839	\$2,403	\$3,420	\$2,218	\$3,157	\$1,109	\$1,579
7	\$65,052	\$92,574	\$5,421	\$7,715	\$2,711	\$3,858	\$2,502	\$3,561	\$1,251	\$1,781
8	\$72,436	\$103,082	\$6,037	\$8,591	\$3,019	\$4,296	\$2,786	\$3,965	\$1,393	\$1,983
For each additional family member, add	+\$7,384	+\$10,508	+\$616	+\$876	+\$308	+\$438	+\$284	+\$405	+\$142	+\$203

These guidelines are based on 130% (free) and 185% (reduced) of the federal poverty guidelines and are effective July 1, 2026 – June 30, 2027.

NEW ☐ UPDATE ☐ DROP IN ☐

Institution Name: Healthy Plate Solutions

Agreement Number: 05001

Facility/Provider Name: _____

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 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 ☐ 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 Birth - 5 months	Today's Date 6 - 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.

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.	
My child is NOT developmentally ready for solid foods. I will inform the provider when and designate the solid food(s) to be introduced to my infant at that time.	

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)

Name of Child Care Facility or Day Care Home Provider: _____

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) OR A HOMELESS CHILD * IF ALL CHILDREN LISTED BELOW ARE FOSTER OR HOMELESS 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 benefits, 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 or day care home provider households) 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 ☐

ADDITIONALLY, PLEASE ATTACH OFFICIAL EVIDENCE OF ENROLLMENT IN THE LISTED PROGRAM. If you are not a day care home provider, do not have a child enrolled at a day care, and/or are not participating in a qualifying program, **skip to Part 4.**

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

A. Name (List only household members with income) (Example) Jane Smith	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
	\$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:

- ☐ 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 meal benefits. You must include the last four digits of the Social Security Number of the adult household member who signs the application; however, 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), or other qualifying program eligibility 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, 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.

This institution is an equal opportunity provider.

Join Texas WIC

We're here for you

“Thanks to WIC,
I now have the tools
I need to make
sure my family
stays on the path to
a healthy lifestyle.”

—Roxie, WIC Client

As a WIC Client, you'll get:

- Delicious food
- One-on-one counseling with nutritionists
- Easy recipes
- Nutrition classes
- Breastfeeding support
- Health and immunization screenings
- Cooking demonstrations
- Personalized support
- Children's activities

Are you eligible?

Eight million women, infants, and children get WIC benefits. WIC is for pregnant women, new parents, infants, and children under five. If you are on Medicaid, TANF, or SNAP you already qualify.

Texas WIC Income Guidelines

Number of people in the home*	Monthly Income	Annual Income
2	\$ 3,261	\$ 39,128
3	\$ 4,109	\$ 49,303
4	\$ 4,957	\$ 59,478
5	\$ 5,805	\$ 69,653
6	\$ 6,653	\$ 79,828

Effective May 1, 2025

* A pregnant woman's household can be increased by the number of infants she is expecting. For more than 6 household members, call your local WIC office.

** Income can also be determined on a weekly or biweekly basis.

Start now. Call 1-800-942-3678 or visit TexasWIC.org



TEXAS
Health and Human
Services



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Building for the Future

This child care receives Federal cash assistance to serve healthy meals to your children. Good nutrition today means a stronger tomorrow!

Meals served here must meet nutrition requirements established by USDA's Child and Adult Care Food Program

Questions? Concerns?

Call USDA at
1-866-873-2263

OR

Food and Nutrition at
1-800-TELL-TDA
(835-5832)

Your child care at

Fraud Hotline: 1-866-5-FRAUD or 1-866-537-2834
P.O. Box 12847 Austin TX 78711
www.SquareMeals.org
USDA is an equal opportunity provider and employer.



Food and Nutrition Division | Child and Adult Care Food Program



TEXAS DEPARTMENT OF AGRICULTURE
COMMISSIONER SID MILLER

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