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
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

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 eligibility 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 (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino	☐ Asian	☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ 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 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.

This institution is an equal opportunity provider.

Hummingbird Child & Adult Nutrition CE:02504
CHILD ENROLLMENT FORM

Facility Name: Miles of Smiles Learning Center #2

IMPORTANT NOTICE: This form must be completed by parent or guardian at the time of enrollment and must be updated yearly. Failure to complete the enrollment form will result in non-payment for this child's meals for this child care center.

CHILD'S(REN) NAME:

Last Name:	First Name:	MI	Date of Birth	Normal hrs in care Arrive	Depart.	Select Days Normally in Care	Select Meals/Snacks Normally Served	Original Date Enrolled	Date Withdrawn
				AM/PM	AM/PM	Mon Tue Wed Thu Fri Sat Sun	BR AM LU PM SU EV		
				AM/PM	AM/PM	Mon Tue Wed Thu Fri Sat Sun	BR AM LU PM SU EV		
				AM/PM	AM/PM	Mon Tue Wed Thu Fri Sat Sun	BR AM LU PM SU EV		
				AM/PM	AM/PM	Mon Tue Wed Thu Fri Sat Sun	BR AM LU PM SU EV		
				AM/PM	AM/PM	Mon Tue Wed Thu Fri Sat Sun	BR AM LU PM SU EV		
				AM/PM	AM/PM	Mon Tue Wed Thu Fri Sat Sun	BR AM LU PM SU EV		
				AM/PM	AM/PM	Mon Tue Wed Thu Fri Sat Sun	BR AM LU PM SU EV		
				AM/PM	AM/PM	Mon Tue Wed Thu Fri Sat Sun	BR AM LU PM SU EV		

If more space is needed, please use additional form.

I certify that I have received the following flyers: (1) Building For the Future notifying me that this child care center receives federal cash assistance to serve health meals to my child(ren) which must meet nutritional requirements established by USDA's Child and Adult Care Food Program. (2) W.I.C. Program Information Flyer. (4) Letter to Households. (5) Parent Complaint Procedures. All flyers were received in the appropriate language.

PARENT/GUARDIAN FIRST NAME: ______________________ **LAST NAME:** ______________________

Address: ______________________ **Phone Number:** ______________________

City: ______________________ **State:** __________ **Zip Code:** __________

Signature of Parent or Guardian: ______________________ **Date Signed:** ______________________

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CACFP INFANT FEEDING PREFERENCE FORM

Infant's Name _____ Infant's Date of Birth _____

Date Enrolled _____

_____ will feed your infant breast milk provided by you and/or we will
(Name of Facility)
provide iron fortified infant formula.

The Infant Formula Provided by this child care provider is: _____

Breast milk and/or Formula preference

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 (or) I will breastfeed my infant at the site.		
I want the child care provider to provide the infant formula it offers for my infant.		
I will bring the infant formula for my infant. Please list the kind of infant formula you will bring: _____		

Preference regarding infant cereal and other foods

Please mark your preference	**Today's Date** _____ **6 - 11 months**
My child is developmentally ready for solid foods. I want the child care provider to provide the infant cereal and other foods for my infant.	
My child is developmentally ready for solids. 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.	

Parents (or guardian's) Signature _____ Date of Signature _____

1. **This form must be kept on file for each infant enrolled for child care.**
2. **This form must be kept current and accurate for each infant enrolled for child care until the infant reaches one year of age.**
3. **If the parent (or guardian) provides expressed breast milk and the child care provider feeds it to the child, and/or if the mother breast feeds her. child on site, the meal may be claimed for reimbursement.**
4. **If the parent (or guardian) declines the formula and the child care provider provides meal and/or snack components, the meal may be claimed for reimbursement.**
5. **If the parent (or guardian) declines infant meals/snack, meals and snacks may NOT be claimed for reimbursement.**