

ORGANIZATION NAME

PROGRAM YEAR

**CHILD CARE ENROLLMENT FORM**

For Parents/Guardians to Complete

Participants' Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Participants' Home Address: \_\_\_\_\_

Participants' Home Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Mother's Employer &amp; Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Work Hours: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Father's Employer &amp; Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Work Hours: \_\_\_\_\_

Hours of Care Needed: \_\_\_\_\_

Days: \_\_\_\_ Monday \_\_\_\_ Tuesday \_\_\_\_ Wednesday \_\_\_\_ Thursday \_\_\_\_ Friday \_\_\_\_ Saturday \_\_\_\_ Sunday

Meals Needed: \_\_\_\_ Breakfast \_\_\_\_ AM Snack \_\_\_\_ Lunch \_\_\_\_ PM Snack \_\_\_\_ Supper

Special Needs of Participants: \_\_\_\_\_

Medical Information: (Allergies, Sickness) \_\_\_\_\_

**NAMES OF TWO OTHER PERSONS WHO CAN BE CONTACTED IN CASE OF AN EMERGENCY**

NAME \_\_\_\_\_

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_

CITY \_\_\_\_\_

PHONE # \_\_\_\_\_

PHONE # \_\_\_\_\_

Parent's Signature \_\_\_\_\_

Date Signed \_\_\_\_\_

For Provider or Center to Complete

Enrollment Date \_\_\_\_\_

Participants' Age \_\_\_\_\_

Withdrawal Date \_\_\_\_\_

Reason for Withdrawal \_\_\_\_\_

## Family Meal Application for the Child and Adult Care Food Program 2024-2025

<b>Part 1. All Household Members</b>				
<b>Name of Enrolled Child(ren):</b>				
<b>Names of all household members</b> (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"/>	<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 received [MS SNAP], [FDPIR], or [MS TANF cash assistance], 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.** If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call [Your School, Homeless Liaison, Migrant Coordinator at Phone #]      Homeless ☐      Migrant ☐      Runaway ☐

**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> <i>Jane Smith</i>	<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	\$ /
	\$ /	\$ /	\$ /	\$ /
	\$ /	\$ /	\$ /	\$ /
	\$ /	\$ /	\$ /	\$ /
	\$ /	\$ /	\$ /	\$ /
	\$ /	\$ /	\$ /	\$ /

**Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)**  
An adult household member must sign this form. **If Part 3 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 Statement on the back of this 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:
<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander

### 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: \_\_\_\_\_

Temporary: Free \_\_\_\_ Reduced \_\_\_\_ Time Period: \_\_\_\_\_ (expires after \_\_\_\_ days)

Determining Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Confirming Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Follow-up Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.**

Household Size	Yearly
1	\$27,861
2	\$37,814
3	\$47,767
4	\$57,720
5	\$67,673
6	\$77,626
7	\$87,579
8	\$97,532
Each additional person:	+\$9,953

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 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 eligibility information.

## Family Meal Application for the Child and Adult Care Food Program 2024-2025

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, audiotope, 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](mailto:program.intake@usda.gov)

This institution is an equal opportunity provider.