South Carolina Department of Social Services

INFANT STATEMENT

From: Child Care Center/Provider _____

Sponsoring Organization: T & T Tutor World, Inc.

To: **Parent/Guardian of Infant(s) in Child Care**

I am required by the Child and Adult Day Care Food Program to **offer** a CACFP meal to all enrolled infants in my care. A CACFP meal includes iron fortified infant cereal and baby food when appropriate for the child's age, at no additional charge.

I am required to **offer** an infant formula, which meets program requirements to all enrolled infants in my care. The formula that I am providing is iron fortified _____. There will be no additional charge to you, if you would like your infant to receive the formula and/or age appropriate food that I am offering.

I understand that not all infants need the same formula, and that the formula served to your infant should be the one recommended by your physician. If you choose, you may continue to provide your infant's formula or other food items.

Parent/Guardian, please check the following statement that applies to you. Then sign and date below:

Name of Infant: _____ **Birth Date:** _____

Please select only one check box

☐ I would like the child care provider to serve my infant the iron fortified infant formula listed above. When my child is developmentally ready, I understand that besides the formula, the caregiver will offer my infant other food items, approved by the CACFP meal pattern guidelines, at no additional charge to me.

☐ I will supply the breast milk/infant formula to the child care provider to serve to my infant. The name of the formula I will provide is: _____. I understand that the caregiver will offer other food items, approved by the CACFP meal pattern guidelines, to my child when developmentally ready.

☐ I will supply the breast milk on site or express. I understand that the caregiver will offer other food items, approved by the CACFP meal pattern guidelines, to my child to my child when developmentally ready.

☐ I will provide breast milk/infant formula and all other meal items to my child care provider to serve to my infant. The name of the formula I will provide is _____.

Note: You will need to provide a medical statement for exempt formulas such as Nutramigen, NeoSure or Alimentum.

If there are any changes from your above selection, a new form is required.

Signature of Parent/Guardian: _____ **Date:** _____

Signature of Provider: _____ **Date:** _____

DSS
SOUTH CAROLINA
DEPARTMENT of SOCIAL SERVICES

SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES
CACFP MEAL BENEFIT INCOME ELIGIBILITY (CHILD CARE)

COMPLETE ONE APPLICATION PER HOUSEHOLD. PLEASE USE A PEN (NOT A PENCIL).

STEP 1 List ALL Household Members who are infants, children, and students up to and including grade 12. (If more spaces are required for additional names, attach another sheet of paper)

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related.
Children in Foster Care and children who meet the definition of **Homeless, Migrant or Runaway**, are eligible for free meals.

CHILD'S FIRST NAME	(MI)	(LAST NAME)	CHECK ALL THAT APPLY: ENROLLED IN CHILD CARE	FOSTER CHILD	HEAD START	HOMELESS/MIGRANT/RUNAWAY
			☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
			☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
			☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
			☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
			☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

STEP 2 Do any household members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF (FI), or FDPIR?

IF NO > Go to STEP 3

IF YES > Write case number here and proceed to STEP 4 (do not complete STEP 3)

CASE NUMBER:

Write only one case number in this space.

STEP 3 Total Household Gross Income

Are you unsure what income to include here? Turn to page 3 and review the charts titled, "Sources of Income" for more information.
The "**Sources of Income for Children**" chart will help you with the Child Income section. The "**Sources of Income for Adults**" chart will help you with All Adult Household Members section.

A. Child Income

Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here

Child Income	How often? Weekly	Bi-Weekly	2x Month	Monthly
$	☐	☐	☐	☐

B. All Adult Household Members (including yourself)

List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write "0" or leave any fields blank, you are certifiying (promising) that there is no income to report

Name of Adult Household Members (First and Last)	Earnings from Work	How often? Weekly	Bi-Weekly	2x Month	Monthly	Public Assistance Child Support Alimony	How often? Weekly	Bi-Weekly	2x Month	Monthly	Pensions/Retirement Social Security/SSI/ VA Benefits/ Other	How often? Weekly	Bi-Weekly	2x Month	Monthly
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

Total Household Members (Children and Adults) ☐

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member: X X X - X X - _ _ _ _

Check if No SSN ☐

STEP 4 Contact Information and adult signature.

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

PRINT NAME OF ADULT SIGNING FORM	SIGNATURE OF ADULT	DATE

ADDRESS	CITY	STATE	ZIP	PHONE/EMAIL

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OPTIONAL Children's Ethnic and Racial Identities (Optional)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

(Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

(Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

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, the funds your child care enter/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of 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 or other FDPIR identifier for your child 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 the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

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:

MAIL*: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

FAX: (833) 256-1665 or (202) 690-7442;
or
EMAIL: program.intake@usda.gov.

This institution is an equal opportunity provider.

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Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

Total Income	How often? Weekly	Bi-Weekly	2x Month	Monthly	Household Size	Categorial Eligibility	Eligibility FREE	REDUCED	PAID	For Child Care Homes Only:
	☐	☐	☐	☐		☐	☐	☐	☐	Tier I ____ Tier II ____

Determining Official's Signature	Date	Confirming Official's Signature	Date