

Play, Learn, Construct & Conserve Child Care Center

participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents or guardians to annually review and make changes to enrollment data.

CHILD(REN) INFORMATION

<p>Center Enroll Date <input type="text"/> / <input type="text"/> / <input type="text"/></p> <p>Child's First Name <input type="text"/></p> <p>Child's Last Name <input type="text"/></p> <p>Child's Birth Date <input type="text"/> / <input type="text"/> / <input type="text"/></p> <p>Normal Days In Care Center's Days of Operation: -M-F <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F <input type="checkbox"/> SA <input type="checkbox"/> SU</p> <p>Normal Hours In Care Center's Hours of Operation: -06:30 AM-06:00 PM <input type="checkbox"/> AM to <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> PM</p> <p>Meals/Snacks Child Receives Meals/Snacks Served at Center: -SUP, PMS, LUN, BRK <input type="checkbox"/> BRK <input type="checkbox"/> AMS <input type="checkbox"/> LUN <input type="checkbox"/> PMS <input type="checkbox"/> SUP <input type="checkbox"/> EVS</p>	<p>Ethnic Identity (Check one) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino</p> <p>Racial Identity (Check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Black / African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian / Alaskan <input type="checkbox"/> Native Hawaiian / Other Pacific Islander</p> <p>Gender Identity (Check one) <input type="checkbox"/> Female <input type="checkbox"/> Male</p>	<p>SITE / SPONSOR USE ONLY</p> <p>Withdrawal Date: ____ / ____ / ____</p> <p>Re-Enroll Date: ____ / ____ / ____</p>
<p>Center Enroll Date <input type="text"/> / <input type="text"/> / <input type="text"/></p> <p>Child's First Name <input type="text"/></p> <p>Child's Last Name <input type="text"/></p> <p>Child's Birth Date <input type="text"/> / <input type="text"/> / <input type="text"/></p> <p>Normal Days In Care Center's Days of Operation: -M-F <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F <input type="checkbox"/> SA <input type="checkbox"/> SU</p> <p>Normal Hours In Care Center's Hours of Operation: -06:30 AM-06:00 PM <input type="checkbox"/> AM to <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> PM</p> <p>Meals/Snacks Child Receives Meals/Snacks Served at Center: -SUP, PMS, LUN, BRK <input type="checkbox"/> BRK <input type="checkbox"/> AMS <input type="checkbox"/> LUN <input type="checkbox"/> PMS <input type="checkbox"/> SUP <input type="checkbox"/> EVS</p>	<p>Ethnic Identity (Check one) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino</p> <p>Racial Identity (Check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Black / African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian / Alaskan <input type="checkbox"/> Native Hawaiian / Other Pacific Islander</p> <p>Gender Identity (Check one) <input type="checkbox"/> Female <input type="checkbox"/> Male</p>	<p>SITE / SPONSOR USE ONLY</p> <p>Withdrawal Date: ____ / ____ / ____</p> <p>Re-Enroll Date: ____ / ____ / ____</p>
<p>Center Enroll Date <input type="text"/> / <input type="text"/> / <input type="text"/></p> <p>Child's First Name <input type="text"/></p> <p>Child's Last Name <input type="text"/></p> <p>Child's Birth Date <input type="text"/> / <input type="text"/> / <input type="text"/></p> <p>Normal Days In Care Center's Days of Operation: -M-F <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F <input type="checkbox"/> SA <input type="checkbox"/> SU</p> <p>Normal Hours In Care Center's Hours of Operation: -06:30 AM-06:00 PM <input type="checkbox"/> AM to <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> PM</p> <p>Meals/Snacks Child Receives Meals/Snacks Served at Center: -SUP, PMS, LUN, BRK <input type="checkbox"/> BRK <input type="checkbox"/> AMS <input type="checkbox"/> LUN <input type="checkbox"/> PMS <input type="checkbox"/> SUP <input type="checkbox"/> EVS</p>	<p>Ethnic Identity (Check one) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino</p> <p>Racial Identity (Check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Black / African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian / Alaskan <input type="checkbox"/> Native Hawaiian / Other Pacific Islander</p> <p>Gender Identity (Check one) <input type="checkbox"/> Female <input type="checkbox"/> Male</p>	<p>SITE / SPONSOR USE ONLY</p> <p>Withdrawal Date: ____ / ____ / ____</p> <p>Re-Enroll Date: ____ / ____ / ____</p>

PARENT / GUARDIAN INFORMATION

<p>I certify the information on this form is true and correct to the best of my knowledge and that I have received access to WIC and CACFP literature within the last 12 months.</p> <p>Signature _____ Date _____</p>	<p>Parent's First Name <input type="text"/></p> <p>Parent's Last Name <input type="text"/></p> <p>Cell Phone <input type="text"/> - <input type="text"/> - <input type="text"/></p>
<p>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, found online at 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. 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). USDA is an equal opportunity provider and employer.</p>	



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 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) <i>(Example)</i> <i>Jane Smith</i>	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 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, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](http://www.ascr.usda.gov/complaint_filing_cust.html), (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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;
- (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

**INSTRUCTIONS FOR
CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM
(CHILD CARE)**

Follow these instructions, if your household gets SNAP, TANF or FDPIR:

Part 1: List all enrolled children and household members.

Part 2: List the eligibility number for any household members (including adults) receiving SNAP or TANF or FDPIR benefits. The SNAP or TANF number must be the 8 or 9 digit EDG# assigned by HHSC (see illustration).

Part 3: Skip this part.

Part 4: Skip this part.

Part 5: Sign the form. The last four digits of a Social Security Number are **not** necessary.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

The illustration shows a portion of a form from the Texas Health and Human Services Commission. At the top right, it says 'Form: TI-0001 October 2006' and 'TEXAS Health and Human Services Commission'. On the left, there is a 'Case Number:' field with a large black 'X' over it, and a 'Date:' field. Below that is a 'Notice of Case Action' section with 'Medicaid Programs' and 'Food Stamp Program' listed. At the bottom, there are fields for 'Contact Name: Geneva Walker Tins001', 'Contact Phone: 214-111', and a table with columns for 'Period', 'Action', 'Benefit', and 'Who's Included'. A callout box on the right explains 'EDG = Eligibility Determination Group # 8-9 digit number' and has an arrow pointing to the 'Eligibility Group Number: 12345678' field, which is circled in red.

If you are applying on behalf of a FOSTER CHILD, follow these instructions:

If **all** children you are applying for are foster children, or if you are only applying for benefits for the foster child:

Part 1: List all foster children. Check the box indicating that the child is a foster child.

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Skip this part.

Part 5: Sign the form. A Social Security Number is **not** necessary.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

If some of the children in the household are foster children.

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster child.

Part 2: If the household does not have an eligibility number, skip this part.

Part 3: Applies only to parents/guardians of children in Tier II Day Care Homes. Sponsors must provide the *List of Eligible Federal/State Funded Programs (H1660)*, with this form to households with children enrolled in Tier II Day Care Homes. Parents/Guardians can enter the program name and number as applicable.

Part 4: Follow these instructions to report total household income from this month or last month.

Column A – Name: List only the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly. See next.

Box 1: List the **gross income**, not the take-home pay. Gross income is the amount earned before taxes and **other deductions**. **You should be able to find it on your stub or your boss can tell you.**

Box 2: List the amount each person got from the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, report income after expenses in Box 1. Box 4 is for your business, farm or rental property. Do not include income from SNAP, TANF, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box."

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Follow these instructions to report total household income from this month or last month.

Column A – Name: List only the first and last name of each person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.

Box 2: List the amount each person got from the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, report income after expenses in Box 1. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

Privacy Act Statement: This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.