ENROLLMENT FOR CHILD AND ADULT CARE FOOD PROGRAM

Name of Child Care Center:	ABC Child Care

Important: This form must be updated annually.

Name(s) of Enrolled Children: (Please print)	Times of Care							Meals Served (Check meals that apply)				
	M	TU	WE	TH	FR	SA	SU	Breakfast	AM Snack	Lunch	PM Snack	Supper
1. Mike Althaus, Jr	Arrival 8:20 Departure 5:45	Arrival 8:20 Departure 5:45	Arrival 8:20 Departure 5:45	Arrival 8:20 Departur 5:45	Arrival 8:20 Departure 5:45	Arrival Departure	Arrival Departure	✓		✓	✓	
2.	Arrival Departure	Arrival Departure	Arrival Departure	Arrival Departur	Arrival Departure	Arrival Departure	Arrival Departure					
3.	Arrival Departure	Arrival Departure	Arrival Departure	Arrival Departur	Arrival Departure	Arrival Departure	Arrival Departure					
4.	Arrival Departure	Arrival Departure	Arrival Departure	Arrival Departur	Arrival Departure	Arrival Departure	Arrival Departure					
5.	Arrival Departure	Arrival Departure	Arrival Departure	Arrival Departur	Arrival Departure	Arrival Departure	Arrival Departure					

Janet Althaus

Printed Name of Parent/Guardian

Janet Althaus

Signature of Parent/Guardian

Writing the parent email address will help us update the form annually

5/4/18

Date Signed

Email: jalthaus@gmail.com

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EXAMPLE

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members

Name of Enrolled Child(ren):

Parents write all members of their family, and check who does not receive an income.

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
Mike Althaus, Jr.	☐	☒
Michael Althause	☐	☐
Janet Althaus	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

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: Janet Althaus ELIGIBILITY NUMBER: 7 8 9 5 2 4 5 6 7 5

If the family has a TANF or SNAP number, write it here. It is always 9 digits long. The parent is done and can skip to the bottom to sign and date the form.

Part 3. (Applies o **e home)** If any member of your household receives benefits listed on t *660)*, provide the name of the program and eligibility number: NAME: _____ Y NUMBER: _____
Check here if no e

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		
(Example) *Jane Smith*	$200/weekly	$150/twice a month		
Michael Althaus	$_____/_____	$~~200~~/ ~~Week~~		
Janet Althaus	$_____/_____	$~~800~~/ ~~Month~~	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

If the parent does NOT have a TANF or SNAP number, they should write their income and frequency. The parent must also put the last 4-digits of their Social Security Number.

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: Janet Althaus Print name: Janet Althaus

Date: 5/4/18

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: _*_*_*-_*_*-_4615_ ❑ 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:	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.

If the parent does not fill this out, the center staff must fill it out using a visual determination

☐ **I do elect to allow my household information to be disclo**

☐ **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, audiotape, 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, (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.

ENROLLMENT FOR CHILD AND ADULT CARE FOOD PROGRAM

Name of Child Care Center:	

Important: This form must be updated annually.

Name(s) of Enrolled Children: (Please print)	Times of Care							Meals Served (Check meals that apply)				
	M	TU	WE	TH	FR	SA	SU	Breakfast	AM Snack	Lunch	PM Snack	Supper
1.	Arrival / Departure	Arrival / Departure	Arrival / Departure	Arrival / Departur	Arrival / Departure	Arrival / Departure	Arrival / Departure					
2.	Arrival / Departure	Arrival / Departure	Arrival / Departure	Arrival / Departur	Arrival / Departure	Arrival / Departure	Arrival / Departure					
3.	Arrival / Departure	Arrival / Departure	Arrival / Departure	Arrival / Departur	Arrival / Departure	Arrival / Departure	Arrival / Departure					
4.	Arrival / Departure	Arrival / Departure	Arrival / Departure	Arrival / Departur	Arrival / Departure	Arrival / Departure	Arrival / Departure					
5.	Arrival / Departure	Arrival / Departure	Arrival / Departure	Arrival / Departur	Arrival / Departure	Arrival / Departure	Arrival / Departure					

_____ _____

Printed Name of Parent/Guardian

Signature of Parent/Guardian

_____

Date Signed

Phone Number of Parent/Guardian: _____

This page is left blank intentionally to facilitate double-sided printing.

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

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

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	

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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:_____

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Non-discrimination Statement:

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(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.

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