

VIRGINIA CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS and FAMILY DAY HOMES

1	All Household Members	2	3																	
NAMES OF ALL HOUSEHOLD MEMBERS [Adults and Children]		FOSTER CHILD		SNAP, TANF or FDIPIR CASE #																
First, Middle Initial, Last		Check if NO income	Ages of children in care	Skip to Part 6 if all are foster children.		Skip to Part 6 if you list a SNAP, TANF or FDIPIR case number.														
				SNAP and TANF MUST BE NINE (9) DIGITS																
1	<i>Jimmy Confused</i>	<input checked="" type="checkbox"/>		<input type="checkbox"/>																
2	<i>Ima Confused</i>	<input type="checkbox"/>		<input type="checkbox"/>		<i>7</i>	<i>3</i>	<i>5</i>	<i>2</i>	<i>6</i>	<i>7</i>	<i>8</i>	<i>0</i>	<i>4</i>						
3		<input type="checkbox"/>		<input type="checkbox"/>																
4		<input type="checkbox"/>		<input type="checkbox"/>																
5		<input type="checkbox"/>		<input type="checkbox"/>																
6		<input type="checkbox"/>		<input type="checkbox"/>																

The parent writes down everyone in the household and checks off who does not have an income.

If a parent has a TANF or SNAP/Food Stamp number, they write it here (This number is ALWAYS 9 digits. The parent may now sign and date the form.)

4 Homeless Migrant Runaway If any child you are responsible for is a foster child, check the appropriate box.

5 Total Household Gross Income (before deductions). You must list all household members with income.		GROSS INCOME AND HOW OFTEN IT IS RECEIVED (Example: \$100/week)							
NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	Earnings From Work		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Comp, Unemployment, SSI, etc.		
	Amount	How often?	Amount	How often?	Amount	How often?	Amount	How often?	
i. <i>Ima Confused</i>	<i>\$ 400</i>	<i>Week</i>	\$		\$		\$		
ii.	\$		\$		\$		\$		
iii.	\$		\$		\$		\$		
iv.			\$		\$		\$		
v.			\$		\$		\$		

is *4632* Social Security Number I do not have a social security number.

If the parent does not have a TANF or SNAP number, they may still qualify based on their income. They write down all of their household income. Remind them to put HOW OFTEN! And then they must write down the last 4-digits of their Social Security number.

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.

11/5/18 *Ima Confused* *Ima Confused*

Date Printed Name of Adult Household Member Signature of Adult Household Member

7 Contact Information (Optional)

Work Telephone Number (Include Area Code) Home Telephone Number (Include Area Code) Home Address (Number, Street, City, State, Zip Code)

8 Optional - Sharing Information with Virginia's Health Insurance Program for Children (FAMIS)

May we share your information on this application with the FAMIS, the complete health insurance program for every child in Virginia? If yes, do not sign below.

No, I do not want my information from this application shared with the FAMIS. Date: Sign here:

Sponsor use only

SECTION A Annual Income Conversion: Weekly X 52 Every 2 Weeks X 26 Twice a Month X 24 Once a Month X 12 Convert income only if different frequencies of pay are reported.

TOTAL INCOME Per \$ _____ Week Every 2 Weeks Twice a Month Month Year NUMBER IN HOUSEHOLD: _____

FREE based on: foster child migrant SNAP or TANF household income REDUCED based on: household income DENIED reason: income too high incomplete application non-qualifying SNAP/TANF

SECTION B Signature of Determining Official: Date:

Virginia Child and Adult Care Food Program (CACFP)

Annual Enrollment Form (Child)

CENTER/PROVIDER COMPLETE THIS SECTION

Center/Provider Name

VA

Street Address

City

State

Zip Code

This institution participates in the Child and Adult Care Food Program (CACFP) and receives Federal reimbursement to provide nutritious meals for children. Federal CACFP regulations require all parents/guardians to complete and sign a separate Annual Enrollment Form for each child when enrolling their child(ren) with this provider, and every 12 months thereafter. **The parent or guardian must complete and ensure accuracy of Sections 1 through 5 below.**

This form is required for:

Child Care Centers, Family Day Care Homes

This form is NOT required for:

Outside School Hours Care Centers, Emergency Shelters

1	FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	2	DAYS OF WEEK IN ATTENDANCE	3			TIMES CHILD NORMALLY ATTENDS CARE DURING THE WEEK	4	MEALS RECEIVED
	<i>Child's First Name</i>	<input type="checkbox"/> Monday	<input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday	TIME IN	TIME OUT	SPORADIC SCHEDULE (no set schedule of days)	<input type="checkbox"/> Breakfast <input type="checkbox"/> AM Snack <input type="checkbox"/> Lunch <input type="checkbox"/> PM Snack <input type="checkbox"/> Supper <input type="checkbox"/> EV Snack		
	<i>Child's Last Name</i>								
	<i>Date of Birth (mm/dd/yyyy)</i>			NOTES:					
	<i>Age</i>								

Parent/Guardian Signature and Date:

5 *By signing this form, I certify that I am the parent/legal guardian of the child named in Section 1 of this Annual Enrollment Form and that the information contained on this form is true and correct.*

Printed Name

Signature

Street Address

City, State, Zip Code

Phone Number HOME / WORK / CELL (circle one)

Date

Nondiscrimination 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.

Effective Date of This Enrollment Form:

(mm/dd/yyyy)

Effective Withdrawal Date of This Enrollment Form:

(mm/dd/yyyy)

The effective date may be retroactive to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.

Printed Name of Center Representative

This form is effective for 12 months from the date of parent signature.

Signature of Center Representative

**Revised March 2019.
Previous Versions Obsolete**

Classroom

VIRGINIA CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS and FAMILY DAY CARE HOMES

Center Name _____

1 All Household Members		2	3
NAMES OF ALL HOUSEHOLD MEMBERS (Adults and Children)		FOSTER CHILD	SNAP, TANF or FDPIR CASE #
First, Middle Initial, Last		Skip to Part 6 if all are foster children.	Skip to Part 6 if you list a SNAP, TANF or FDPIR case number.
Check if NO income		Ages of children in care	
		SNAP AND TANF MUST BE NINE (9) DIGITS	
1	<input type="checkbox"/>	<input type="checkbox"/>	
2	<input type="checkbox"/>	<input type="checkbox"/>	
3	<input type="checkbox"/>	<input type="checkbox"/>	
4	<input type="checkbox"/>	<input type="checkbox"/>	
5	<input type="checkbox"/>	<input type="checkbox"/>	
6	<input type="checkbox"/>	<input type="checkbox"/>	

4 Homeless, Migrant, or Runaway
 Homeless Migrant Runaway If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call your School Homeless Liaison or Migrant Coordinator.

5 Total Household Gross Income (before deductions). You must tell us how much and how often.

NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	GROSS INCOME AND HOW OFTEN IT IS RECEIVED (Example: \$100/month, \$100/twice a month, \$100/every other week, \$100/week)							
	Earnings From Work		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Comp, Unemployment, SSI, etc.	
	Amount	How often	Amount	How often	Amount	How often	Amount	How often?
i.	\$		\$		\$		\$	
ii.	\$		\$		\$		\$	
iii.	\$		\$		\$		\$	
iv.	\$		\$		\$		\$	
v.	\$		\$		\$		\$	

6 Signature and Social Security Number (Adult must sign)
 An adult household member must sign the application. If Part 5 is completed or if zero income is listed, 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.
 _____ Social Security Number I do not have a social security number.

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.

Date _____ Printed Name of Adult Household Member _____ Signature of Adult Household Member _____

7 Contact Information (Optional)
 Work Telephone Number (Include Area Code) _____ Home Telephone Number (Include Area Code) _____ Home Address (Number, Street, City, State, Zip Code) _____

8
 May we share your information on this application with the FAMIS, the complete health insurance program for every child in Virginia? If yes, do not sign below.
 No, I do not want my information from this application shared with the FAMIS. Date: _____ Sign here: _____

CHILD CARE RESOURCES REPRESENTATIVE USE ONLY – ELIGIBILITY DETERMINATION – COMPLETE SECTIONS A and B BELOW

SECTION A Annual Income Conversion: Weekly X 52 Every 2 Weeks X 26 Twice a Month X 24 Once a Month X 12 Convert income only if different frequencies of pay are reported.

TOTAL INCOME Per \$ _____ Week Every 2 Weeks Twice a Month Month Year NUMBER IN HOUSEHOLD: _____

FREE based on: REDUCED based on: DENIED reason:

foster child migrant SNAP, TANF, FDPIR household income income too high incomplete application
 homeless runaway household income non-qualifying SNAP/TANF

SECTION B Signature of Determining Official: _____ Date: _____

Nondiscrimination 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.

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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.