			Innual CACFP En			(Child)				
	CENT	ΓER/F	PROVIDER COMPLE		ECTION					
		7	APC Child C	re						
	LX		Centε 'P. vider ar							
112 Main Stre	Ric mo	nd	<u>VA</u>	2321	9					
		City	State	Zip Co	ode					
	tes in the Child and Adult C	_			eimburseme	ent to provide nutritiou	s meals for o			
	e sure that the correct	1000	to complete and sign a	CONTROL PROPERTY.	The me	als expected to be	received	their		
child(ren) with this p bi	irthdate and child's	aı	ter. The parent or guar below.	dian must (		correlate with the	ougn			
cla	assroom are written ii	n.			times th	11011111				
	re Centers, Family Day C			At-F		hool Centers, Emerg	ency Shelte	ers		
	Outside School Jours C	are C	enters	1237 1.		moory enters, Emerg	erio, Gireici			
1 FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)  Date/Age)  DAYS OF WEEK IN ATTENDANCE			3 TIMES CHILD NOR	RMALLY AT	TENDS CAR	DURING THE WEEK	4	EALS EIVED		
Kinggan		$\neg$	TIMES IN	710.41	COURT	SPORADIC SCHEDULE				
Jimmy	☑ Monday		TIME IN	TIME	OUT	(no set schedule of days)	☑ Breakfa	st		
Child's First Name		Ī					☐ AM Snack			
confused	■ Wednesday		8:30	5:45			☑ Lunch			
Child's Last Name	☑ Thursday	ļ					☑ PM Snack			
9/6/12	🖾 Friday	,	NOTES:				□Supper			
Date of Birth (m/d/yy)  5 Red □ Sunday							☐ EV Snac	k		
Age Classroom	La sunday									
Printed Nai Street Addre			City, Stat	_	maíl.		Oate			
RACIAL/ETHNIC IDEN	TITY (Optional): Please	checl	cappropriate boxes t	o identify	the race ar	d ethnicity of enroll	ed child(re	n).		
American Indian or Al	laska Native	A	sian		E	Black or African American	i			
			Vhite			**				
Please mark one ethnic id	dentity: Hispa	X Not								
NON-DISCRIMINATION STATEMENT: In ac administering USDA programs are prohibit	ccordance with Federal ovil eights law and U. ted from discriminating based on race, color,	.S. Departr , national c	me. t of Agriculture (USDA) civil rights r origin, sex, disability, age, or reprisal or	egulations and poli retaliation for prior	cies, the USDA, its A civil rights activity i	gencies, offices, and employees, and in any program or activity conducted in	institutions participa or funded by USDA.	ting in or		
Persons with disabilities who require alter Individuals who are deaf, hard of hearing, To file a program complaint of discriminal USDA and provide in the letter all of the in 1) mail: U.S. Department of Agricultu Office of the Assistant Secretary for 1400 Independence Avenue, SW Washington, D.C. 20250-9410; 2) fax: (202) 690-7442; or	eth	If the parent does not fill in the child's ethnic and racial data, the center must fill it out based on visual determination.								
3) email: program.intake@usda.gov										
This institution is an equal opport	unity provider									
Sponsor Use Only  Iffective Date of This E	nrollment Form:					The effect of 1				
Effective Withdrawal D		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								
Printed Name of Center Repre	Mr. Proc.	2	is received.  This form is effective for 12 months from the date of parent signature.							
Signature of Center Represent	tative					-				
						Revised July 2017;	Previous Versioi	ns Obsolet		

v	IRGINIA CACFP	MEAL BENEF	IT INCOME	ELIGII	BILITY FOR	M FOR	CHILD CAR	RE CEI	NTER:	Sand	FAM	ILY D	ау но	MES	
1 All Household Members						2		3							
NAMES OF ALL HOUSEHOLD MEMBERS [Adults and Children]						FOSTER CHILD SNAP, TANF or FDPIR CAS						E#			
First, Middle Initial, Last				NO income	Ages of children in care	Skip to Pa foster	Skip to Part 6 if you list a SNAP, TANF or FDPIR case number.  SNAP and TANF MUST BE NINE (9) DIGITS								
1 Jimmy Confused													T	Ī	
2 Ima Confused								チ	3	5	2	6	チ	8 0	4
3											<b></b>			1	
.4															
The parent writes down everyone															
6 in the household and checks off															
4 Hc	who does no	ot have an inc	ome.												
Homeless Migrant					Runaway  If any child you appropriate boo Stamp number, they write it here (This										
5 To	tal Household		ACCORDING TO SECURITION AND ADDRESS OF THE PARTY OF THE P		The second second second	You r	nus	-			_		-	ent	
N	AMES	GROSSING	OME AND HO	W OFTE	OFTEN IT IS RECEIVED (Example stand place) on the parent stand place were standard to the form.									eek,	
/HCT ALI	HOUSEHOLD	Farnings F	rom Work	Welf	fare, Child Su	101.0000			nent, S						
•	L HOUSEHOLD WITH INCOME)		_	wellare, Cilia su			Secu		urity				T	nent, SSI, etc.	
V (10 (10 (10 (10 (10 (10 (10 (10 (10 (10			Amount How often?		Amount			mount	_	How oft	en?	Amount		How often?	
(m)	Confused	\$ 400	Week	\$			\$					\$			
II. III.		\$		\$		\$						\$		<del>                                     </del>	
ive							\$		+			\$		+	
if the parent does not have a TANF or SNAP number, they may still															
	based on thei		=											<u> </u>	
hold income. Remind them to put HOW OFTEN! And then they															
must write down the last 4-digits of their Social Security number.															
	t the last four digit		(E											mber.	12.0
number or m	ark the <i>I do not ha</i>	ive a social secui	ity number bo	ох.											
566	all information on t	and the second s							76		933		199		
	give. I understand se the meal benefit			the info	ormation. Tu	naerstana	tnat if I purp	osely g	jive fai	se infoi	rmatic	n, the	participo	int receiv	ıng
	/18	In	ia Confi	rsed				Im	a Go	nfus	ed				
Da	te	nber		Sig	nature	of Ad	ult Hou	seholo	l Mem	ber					
7 Co	ntact Inform	ation (Optic	nal)	ACCOUNTS TO A SECOND											
	# E = 1 = 1 1 1 1						w.								
Work Telep	ohone Number (Incl	lude Home Te	lephone Numb	her (incl	ude Area Con	<u> </u>	Home	Δddres	c (Nu	mher S	treet	City S	tate, Zip	Code)	r.
	Area Code)		380 a sa sa	23 At 22	2000 - 20 /550	2.0		10 40	5 10	1018 3			naiwa ea	coucy	
8 OF	otional - Shar	ing Informat	tion with \	/irgini	a's Healt	h Insura	ance Prog	ram	for (	Childi	en	(FAIV	IIS)		
May we share	e your information	on this application	on with the FAI	MIS, the	e complete h	ealth insur	ance prograi	m for e	very c	hild in \	/irgini	a? If <b>y</b>	es, do n	ot sign be	low.
□ No,	I do not want my info	ormation from this	D-	i			C!	ü							
app	lication shared with th	ne FAMIS.	Da	ite:			Sign	nere:							
Spoi	nsor 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															
. S	□ FRE	E based on:	Weeks	£02	REDUC	ED based				480-8480-	-130-4176-1502-0	114011170			
☐ FREE based on: ☐ REDUCED based ☐ DENIED reason: ☐ foster child ☐ migrant ☐ SNAP or TANF ☐ household income ☐ income too high ☐ incomplete app									pplication	1					
☐ homeless	☐ runaway	☐ hou	ioia ilitoille	-7			non-qu	ualifyin	g SNAF	P/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 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 NOT required for: This form is required for: Child Care Centers, Family Day Care Homes Outside School Hours Care Centers, Emergency Shelters **FULL NAME OF ENROLLED** DAYS OF WEEK IN MEALS **CHILD (Include Birth** TIMES CHILD NORMALLY ATTENDS CARE DURING THE WEEK 2 ATTENDANCE RECEIVED Date/Age) SPORADIC SCHEDULE TIME OUT TIME IN □ Monday (no set schedule of days) ☐ Breakfast Child's First Name □ Tuesday ☐ AM Snack □ Wednesday ☐ Lunch Child's Last Name ☐ PM Snack □ Thursday ☐ Friday NOTES: □Supper Date of Birth (mm/dd/yyyy) □Saturday ■ EV Snack □ Sunday Parent/Guardian Signature and Date: 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 londiscrimination 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 mployees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliati for prior civil rights activity in any program or activity conducted or funded by USDA. ersons 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:** The effective date may be (mm/dd/yyyy) retroactive to the first day the child **Effective Withdrawal Date of This Enrollment Form:** participates in the CACFP as long as (mm/dd/yyyy) 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. Revised March 2019. Signature of Center Representative 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 Me						2 3										
NAMES OF ALL HOUSEHOLD MEMBERS [Adults and Children]  Check if   Ages of					FOST	ER CHILD	CHILD SNAP, TANF or FDPIR CASE #									
Check if First, Middle Initial, Last NO					Skip to Part 6 if a	ll are foster childre		Skip to Part 6 if you list a SNAP, TANF or FDPIR case number.								
1				care				SNA	AP AND	TANF MU	JST BE I	NINE (9	) DIGITS			
2																
3																
4						_										
5																
6																
4 Homeless, Migra	nt, or Runawa				1	I				I						
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 GROSS INCOME AND HOW OFTEN IT IS RECEIVED (Example: \$100/month, \$100/twice a month, \$100/every other week, \$100/week)																
(LIST ALL HOUSEHOLD MEMBER	s Earnings	Earnings From Work Welfare, Child				upport, Alimony Pensions, Retire										
WITH INCOME)		1	-	Amount	How often	Se Amount	ecurity How often		<u> </u>	Amount		How often?				
i.	Ś	Amount How often		Amount	now orten	\$	HOW C	nten	Ś	Amount			now often:			
ii.	Ś		\$			\$	\$									
iii.	\$		\$			\$			\$							
iv.	\$		\$			\$			\$							
ν.	\$		\$			\$			\$							
6 Signature and Soc			t must													
An adult household member mus completed or if zero income is list			lso	<u>X X X</u>	- <u>X X</u>			_								
list the last four digits of his or he					Social Security N	umber			10	do not h	ave a so	ocial se	curity numb	er.		
not have a social security number	box.															
I certify that all information on this														nd that		
CACFP officials may verify the info	mation. Tunderstand	i that ij i parpose	riy give ji	aise irijormati	оп, тве рапистра	it receiving meai	s muy lose	ine meui	benejits	, unu i m	иу ве р	rosecui	eu.			
Dete	Drinted Names	- f A d lt	1-1 0 0 1-		-		:	A alla 11a		11						
	Date Printed Name of Adult Household Member Signature of Adult Household Member 7 Contact Information (Optional)															
/  Contact Information (Optional)																
Work Telephone Number (Inclu	de Area Home :	Telephone Numb	er (Includ	de Area Code)	)	Ноте	Address (	Number,	Street, C	ity, State	, Zip Co	ode)				
Code) 8																
May we share your information or	this application with	the FAMIS, the	complete	e health insur	ance program for	every child in Vi	rginia? If <b>y</b> e	es, do no	t sign be	low.						
No, I do not want my inform	nation from this applicat	tion Da	te:		_	Sign	here:						_			
shared with the FAMIS.																
CHILD CARE	RESOURCES REI	PRESENTATIV	E USE	ONLY – ELI	GIBILITY DET	ERMINATION	– СОМР	LETE SI	ECTION	IS A an	d B BI	LOW				
SECTION A Ar	nual Income Conve	rsion: Weekly	X 52	Every 2 Wee	eks X 26 Twic	e a Month X 24	Once a	Month 2	K 12		Convert		nly if different fi	requencies		
TOTAL INCOME Per		□ Every 2										of pay	are reported.			
S	☐ Week	Weeks	T	wice a Month	☐ Month	☐ Year		NUN	/IBER IN	HOUSE	HOLD:		<del></del>			
	REE based on:	AD TANE EDDID	-	REDUCE	D based on:		:-L		DENIED		.1-4	-1:4:				
☐ foster child ☐ migrant ☐ homeless ☐ runaway		AP, TANF, FDPIR usehold income		☐ housel	hold income	☐ income too h	iign	□ non-		☐ incomp g SNAP/T		plicatio	1			
<u> </u>	Determining Offici	al:		<u> </u>		Date: _										
Nondiscrimination Statement: In employees, and institutions partic		_			-		_				_			n for		
prior civil rights activity in any pro						, ,	, , , , , , , , , , , , ,		, , -	,,	0-,-					
Persons with disabilities who requ	re alternative means	of communication	on for pro	ogram inform	ation (e.g. Braille	. large print, aud	iotape. Am	erican Si	gn Langu	age. etc.	). shoul	d conta	ct the Agen	cv (State		
or local) where they applied for be	nefits. Individuals wh	no are deaf, hard	of heari	-					-				-			
program information may be mad	e available in languag	es other than En	glish.													
To file a program complaint of disc		_								-			_			
any USDA office, or write a letter a completed form or letter to USDA		d provide in the	letter all	of the inform	ation requested	in the form. To re	equest a co	py of the	complai	nt form,	call (86	6) 632-	9992. Submi	t your		
tompleted form of letter to obbit																
(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.																
Revised August 2019; Previous Ver	SIONS ODSOIECE		THIS INS	utuuon is an i	equai opportunit	y proviaer.										