Virginia Annual CACFP Enrollment Form (Adult)

CENTER COMPLETE THIS SECTION

_____
Center Name

_____ _____ VA _____
Street Address *City* *State* *Zip Code*

An enrollment form must be completed when the participant enters the program. Adult Day Care Centers are responsible for updating each participant's Individual Plan of Care annually and keep the enrollment form on file as long as the participant remains in the program. **The participant or guardian must complete and ensure accuracy of Sections 1 through 5 below**.

1	FULL NAME OF ENROLLED PARTICIPANT (Include Birth Date/Age)	2	DAYS OF WEEK IN ATTENDANCE	3	TIMES PARTICIPANT NORMALLY ATTENDS CARE DURING THE WEEK			4	MEALS RECEIVED
	_____ *First Name* _____ *Last Name* _____ *Date of Birth* _____ *Age*		☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday		**TIME IN**	**TIME OUT**	**SPORADIC SCHEDULE (no set schedule of days)**		☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ EV Snack
					NOTES:				

5 Participant/Guardian Signature and Date:

By signing this form, I certify that I am the participant or legal guardian of the participant named in Section 1 of this 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 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.

Child Care Resources Use Only:

Effective Date of This Enrollment Form: _____ *(m/d/yy)*

Effective Date of Withdrawal: _____ *(m/d/yy)*

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

_____
Printed Name of Center Representative

_____ _____
Signature of Center Representative *Date*

Virginia CACFP Meal Benefit Income Eligibility Form (Adult)

Center Name

1 All Household Members

2

NAME OF ENROLLED ADULT(S): First, Middle Initial, Last	Check if **NO** income	SNAP, SSI, Medicaid, or FDPIR CASE NUMBER Skip to Part 4 if you list a SNAP, SSI, Medicaid, or FDPIR case #. **SNAP MUST BE SEVEN (9) DIGITS** **SSI MUST BE NINE (9) DIGITS** **MEDICAID MUST BE TWELVE (12) DIGITS**
1	☐	
2	☐	
3	☐	

3 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							
	Earnings From Work		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Comp, Unemployment, SSI, etc. (All other income)	
	Amount	**How often**	**Amount**	**How often?**	**Amount**	**How often**	**Amount**	**How often**
i.	$		$		$		$	
ii.	$		$		$		$	
iii.	$		$		$		$	

4 Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Part 3 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.

X X X – X X – ___ ___ ___ ___

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 will get Federal funds based on the information I give. 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 Participant or Legal Guardian* *Signature of Participant or Legal Guardian*

5 Participant's Residency/Living Arrangements

Each adult day care center shall maintain records which document that qualified adult day care participants reside in their own homes (whether alone or with spouses, children or guardians) or in group living arrangements. [*Group living arrangement* means residential communities which may or may not be subsidized by federal, State or local funds but which are private residences housing an individual or a group of individuals who are primarily responsible for their own care and who maintain a presence in the community but who may receive on-site monitoring. 7 CFR 226.2 § 226.19

I _____ [name of participant] reside:

☐ In my own home (alone or with spouse, children, or guardian) ☐ In the home of a family member/guardian ☐ In a residential facility

If residential facility, identify type of facility: ☐ Assisted Living Facility ☐ Nursing Home ☐ Group Home ☐ Other Facility

Name of facility/home _____ Address of facility/home _____

DON'T FILL OUT THIS PART. CHILD CARE RESOURCES 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:
☐ SNAP ☐ SSI ☐ Medicaid ☐ household income ☐ FDPIR	☐ household income	☐ income too high ☐ incomplete application ☐ non-qualifying SNAP/SSI/Medicaid/FDPIR

SECTION B **Signature of Determining Official:** _____ **Date:** _____

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