Virginia CACFP Annual CACFP Enrollment Form (Child)													
CENTER/PROVIDER COMPLETE THIS SECTION													
APC Child Core													
		LV		Cente 'P. vider ar									
112 Main 9	Street			<u> </u>	Ric mo	nd	VA	23219	9				
	Str	reet numerous				City	State	Zip Co	de				
This institution partic	ipates in th	ne Child and Adult Care	e Food I	Program (CACFP) and	d receives re	eimburseme	ent to provide nutritiou	s meals for o	hildren.				
Federal CACFP reg	Be sure	that the correct	13500 1000	complete and sign a	CONTRACTOR CONTRACTOR	The me	als evnected to be	received	their ough 5				
child(ren) with this p	birthda	te and child's	after.	The parent or guar below.	dian must (	The meals expected to be receive should correlate with the "norma							
	classro	om are written in.		below.	i i		normai						
Chilo	Care Cen	ters, Family Day Car	e Hom	es,	Λ÷ D	times the child attends.							
Licen	sed Outsi	de School Hours Car	e Cent	ers	Al-K	At-Risk Afterschool Centers, Emergency She							
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)  DAYS OF WE ATTENDAL			IN 3	TIMES CHILD NOF	RMALLY ATT	TENDS CAR	4 MEALS RECEIVED						
Jimmy		Monday		TIME IN	TIME	OUT	SPORADIC SCHEDULE (no set schedule of days)	☑ Breakfa	ct				
Child's First Nar	me	▼ Tuesday					100 0-110000000000000000000000000000000	☐ AM Snack					
confused				8:30	5.	45		□ Aw Sha	CK				
Child's Last Nar				8.00	<b>O</b> .	( )		☑ PM Snac	ck				
9/6/12	V1820C	☑ Friday	NO	TES:			l .	□Supper					
Date of Birth (m/d	d/yy)	□Saturday						☐ EV Snack					
$\frac{5}{Age}$ Classroom		☐ Sunday											
3		ture and Date:											
			/legal g	uardian of the child	named in S	ection 1 of	this Enrollment Form o	ind that the					
information cont	ained on th	is form is true and co	rect.										
Ima Cont	fused		used		11/5	5/18							
Printed	l Name		ature		D	ate							
Street A	Street Address City, State, Zip Code iconfused@gmail.com												
Phone Number	WORK/CEL	LL (circle one)		Em									
RACIAL/ETHNIC ID	ENTITY (	Optional): Please ch	neck ap	opropriate boxes t	o identify t	he race ar	nd ethnicity of enroll	ed child(re	n).				
American Indian	or Alaska Na		Asiar				Black or African American	1					
Native Hawaiian	or Other Pac	cific Islander	White	е		, i	Other						
Please mark one ethn	ic identity:	Hispanic	or Latin	0	X Not	Hispanic or	Latino						
NON-DISCRIMINATION STATEMEN administering USDA programs are p	T: In accordance working the control of the control	vith Federal collisishts law and U.S. E scriminating based on race, color, nat	epartme. t ional origin,	of Agriculture (USDA) civil rights re se, disability, age, or reprisal or	egulations and polic retaliation for prior	ies, the USDA, its A civil rights activity	Agencies, offices, and employees, and in any program or activity conducted	nstitutions participal or funded by USDA.	ting in or				
USDA and provide in the letter all o	f the information r	ns of communication for program inf ech disabilities may contact USDA thr te the USDA Program Discrimination requested in the form. To request a c	ormation (e. ough the Fe Complaint F opy of the co	geneille, large prot, audiotape, deral Relay — vice at (520) 877-8 form, (AD-3027) found — the omplaint form, call (866) 632-55	America 1339. A 1ttp://v 15thn eth	If the parent does not fill in the child's sed to ethnic and racial data, the center must fill							
<ol> <li>mail: U.S. Department of Ag Office of the Assistant Secretary 1400 Independence Avenue Washington, D.C. 20250-94</li> </ol>	etary for Civil Righ e, SW	ts			it o	it out based on visual determination.							
2) fax: (202) 690-7442; or													
<ol> <li>email: program.intake@us</li> <li>This institution is an equal of</li> </ol>		ter.											
Sponsor Use On													
Effective Date of Th		ent Form:					The effective date	nay ba					
Elicetive Bate of Th	iis Eingiiii		(m/d/y)	<i>(</i> )			The effective date r retroactive to the fi	. 1577	child				
Effective Withdraw	al Date of	This Enrollment For	2000 9000 79.000	·		participates in the CACFP as long as							
				(m/d/yy)			it occurs in the sam						
Printed Name of Center I	Representativ	ve	_	is received.									
	p					This form is effective for 12 months from the							
Signature of Center Representative date of parent signature.													
*							Revised July 2017;	Previous Versior	ns Obsolete				

v	IRGINIA CACFF	MEAL BENE	IT INCOME	ELIGII	BILITY FOR	M FOR	CHILD CAR	RE CEN	NTER:	S and	FAM	ILY D	ау но	MES		
1 All Household Members						2 3						10.00				
NAMES OF ALL HOUSEHOLD MEMBERS [Adults and Children]						FOSTER CHILD SNAP, TANF or FDPIR CASE #						E#				
First, Middle Initial, Last					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				income			5.5.1 5.13 15.13 15.51 be latte (5) bidiis									
2 Ima Confused							チ	3	5	2	6	チ	8 0	)	4	
3										Î	<b></b>					
4											Т					
5 The parent writes down everyone											Т					
6 in the household and checks off																
4 Hc who does not have an income.																
☐ Homeless ☐ Migrant ☐					away appropriate bos Stamp number, they write it here (This											
5 To	tal Househol		CONTRACTOR DESCRIPTION		The state of the s	You r	nus	-			_		-			
N.	AMES	GROSSINO	OME AND HO	N OFTE	OFTEN IT IS RECEIVED (Example \$100) may now sign and date the form.									week	ς,	
///		Farnings F	rom Work	Welf	fare, Child Su		sions, Retirement, Social									
•	. HOUSEHOLD WITH INCOME)		-			pport, Allinony		Security			Unemployment,					
		Amount How often?		4	Amount	How of		mount	_	How of	ten?	Amount		How o	How often?	
2.	confused	\$ 400	Week	\$		\$					\$ \$					
ii. iii.		\$		\$		\$			-			\$		+	<del>                                     </del>	
iv		·					\$		-			\$		+		
if the parent does not have a TANF or SNAP number, they may still										+						
	based on the		=				1									
Sec.	hold income. Remind them to put HOW OFTEN! And then they															
is must w	must write down the last 4-digits of their Social Security number.															
	the last four digit		16										nu	mber.		
and the control of th	ark the <i>I do not ho</i>			10	83	27 (6. 1)	en 92	-		<u>.</u>			2023	20 27		
556	all information on t give.  I understand	and the second s			.9				76		970		199			
meals may los	se the meal benefi	ts, and I may be p	prosecuted.			ider Starra	inden, purp					in the	participo	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	9	
11/5/	<u> 18</u> _	In	ia Confi	rsed				Im	a Go	nfus	red					
Dat	te	Printed Name of	Adult Househo	old Mem	nber		Sig	nature	of Ad	ult Hou	seholo	old Member				
7 Co	ntact Inform	ation (Optic	nal)		28	_,										
	Problem RV Statemen Victoria	rane t					No.								_	
100000000000000000000000000000000000000	hone Number (Inc Area Code)	lude Home Te	elephone Numb	er (Incl	ude Area Cod	le)	Home .	Addres	s (Nui	mber, S	treet,	City, St	tate, Zip	Code)		
8 Op	tional - Shar	ing Informa	tion with V	/irgini	ia's Healt	h Insura	ance Prog	gram	for (	Child	ren	(FAIV	IIS)			
May we share	your information	on this application	on with the FAI	MIS , the	e complete h	ealth insur	ance progra	m for e	very c	hild in '	Virgini	a? If <b>y</b>	es, do no	ot sign b	elov	N.
_ No,	I do not want my info	ormation from this		a			127 1									
appl	ication shared with th	ne FAMIS.	Da	te:			Sign	nere: _								
Sponsor use only																
SECTION A	Annual Inc	come Conversio	n: Weekly X	52 E	very 2 Wee	ks X 26	Twice a Mo	onth X	24	Once a	Mon	th X 1		Convert inc lifferent fre pay are	equer	ncies of
TOTAL S	INCOME Per	□ Week	☐ Every 2 Weeks	ПТ	wice a Month	□ Мо	nth [	] Year		NUMI	BER IN	HOU:	SEHOLD			
	□ FRE	\$6.	REDUC	ED based	d [ **		3,5	□D	ENIED	reaso	n:					
☐ foster child	7.00		□ househ	lincome too high ☐ incomplete app household income ☐ non-qualifying SNAP/TANF												
homeless	□ runaway	ture of Determ	sehold income	8.	<u> </u>						uailiyin	g SINAP	/ I AINF			
SECTION I				Date:												

## Virginia Child and Audit Care Food Program (CACFP) **Annual Enrollment Form (Child) CENTER/PROVIDER COMPLETE THIS SECTION** Alpha Beta Cappa Christian Academy Center/Provider Name 7425 Chesapeake Blvd Norfolk VΔ 23513 Street Address State Zip Code This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide nutritious meals for children. Federal CACFP regulations require all parents/guardians to complete and sign a separate annual Enrollment Form per 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: This form is NOT required for: Child Care Centers, Family Day Care Homes Outside School Hours Care Centers, Emergency Shelter **FULL NAME OF ENROLLED** DAYS OF MEALS TIMES CHILD NORMALLY ATTENDS CARE DURING WEEK CHILD WFFK IN 3 RECEIVED (Include Birth Date/Age) ATTENDANCE TIME IN TIME OUT SPORADIC SCHEDULE (not set schedule of days) Child's First Name Monday Breakfast Tuesday AM Snack Wednesday Lunch NOTES: Child's Last Name Thursday PM Snack Friday Supper Date of Birth (mm/dd/yyyy) Saturday ■ EV Snack Sunday Aae 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 Enrollment Form and that the 5 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 Representative Use Only Effective Date of This Enrollment Form:** The effective date may be retroactive to (mm/dd/yyyy) the first day the child participates in the CACFP as long as it occurs in the same Effective Withdrawal Date of This Enrollment Form: month this form is received. (mm/dd/yyyy) Printed Name of Center Representative This form is effective for 12 months from the date of parent signature.

Signature of Center Representative

	VIRGINIA CA	CFP MEAL BENEFIT	INCOME ELIGI	BILITY FORM	и (IEF) FOR	CHILD CA	ARE CENTERS an	nd FAMILY	DAY	CARE HO	MES	i		
	Center Name	Alpha Be	ta Cappa Christ	ian Academy	/									
1 All Household Members						2	2 3							
NAMES OF ALL HOUSEHOLD MEMBERS [Adults and Children]						FO	FOSTER CHILD SNAP, TANF or FDPIR CASE #							
	First, Middle Initial, Last				Ages of children in		o Part 6 if all are	Skip to Part 6 if you list a SNAP, TANF or FDPIR case number.						
$\vdash$			income	care	fo	ster children.	SNAP and TANF MUST BE NINE (9) DIGITS							
1.														
2.														
3.														
4.														
5.														
6.														
4	Trombiodo, inigrant, or remainay													
If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box  Homeless Migrant Runaway and call your School Homeless Liaison, Migrant Coordinator.											OOX			
5	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			\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	21.11.0		Pensions, Ret	tirement, Soc	1	Worker's Comp,				
	MEMBERS WITH INCOME)	Earnings Fr			Child Support, A		+	curity		Unemployment, SSI, etc.				
		Amount	How Often	Amount How		v Often	Amount	How O	ften	Amo	unt	Ho	w Often?	
i.		\$		\$			\$			\$		+		
ii.		\$		\$			\$			\$		+-		
iii.		\$		\$	_		\$	1		\$		+		
iv.		\$		\$			\$		\$					
۷.		\$		\$			\$	\$						
6 4n	- J	<u> </u>		1)										
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.  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 j	prosecuted.													
_	Date Common time (	Outional)	Printed Name o	of Adult Househo	old Member			Signature o	of Adult	Household	Memb	er		
	Contact Information (C	Optional)	, ,											
-	Work Telephone Number (I	Include Area Code)	( ) Home T	elephone Numb	oer (Include Are	a Code)	Home	Address (Nu	mher S	Street City	State	Zin Co	nde)	
8	Optional - Sharing Info	,		·				Address (IVU	iliber, s	sireer, City,	State,	ZIP CC	oue)	
	we share your information on th	-						not sian belo	w.					
,	No, I do not want my inform shared with the FAMIS.		•	Date _			Sign Here							
	CHILD CAR	RE REPRESENTAT	VE USE ONLY	- ELIGIBILIT	Y DETERMI	NATION -	- COMPLETE SE	ECTIONS	A and	B BELC	W			
CE	CTT ON A							(				nt freque	encies of pay	
		Annual Income Convers		_very z weeks z						are	reporte	ed.		
\$_	OTAL INCOME Per	☐ Week ☐ Ev	ery 2 Weeks	☐Twice a Month	n	n 🗆 Ye	ear NI	UMBER IN H	OUSEH	IOLD:			_	
	☐ FREE based	on:	□R	EDUCED based	on:			DENIED R	eason:					
_	foster child migrant	☐SNAP, TANF, F		household inc	ome	income	_		/TANIE	inco	mplete	e applio	cation	
	homeless runaway  CTION B	household incor	ne		-		non-qua	lifying SNAP						
	Oignature of	f Determining Official:						_ Date						
emp	discrimination statement: In ac ployees, and institutions participa	ting in or administering l	JSDA programs are	•	• ,	,		•						
المالم	r civil rights activity in any progra	or activity colludoted (	n ranged 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:														
Offic 140 Was (2) f	mail: U.S. Department of Agricultice of the Assistant Secretary for 0 Independence Avenue, SW shington, D.C. 20250-9410; fax: (202) 690-7442; or	Civil Rights												
(3)	email: program.intake@usda.gov			This instituti	on is an equal o	nnortunity r	provider							