

Virginia CACFP Annual CACFP Enrollment Form (Child)

CENTER/PROVIDER COMPLETE THIS SECTION

112 Main Street, ABC Child Care, Richmond, VA, 23219

This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide nutritious meals for children.

Be sure that the correct birthdate and child's classroom are written in.

The meals expected to be received should correlate with the "normal" times the child attends.

Child Care Centers, Family Day Care Homes, Licensed Outside School Hours Care Centers

At-Risk Afterschool Centers, Emergency Shelters

Table with columns: 1 FULL NAME OF ENROLLED CHILD, 2 DAYS OF WEEK IN ATTENDANCE, 3 TIMES CHILD NORMALLY ATTENDS CARE DURING THE WEEK, 4 MEALS RECEIVED. Includes handwritten entries for Jimmy Confused.

5 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 information contained on this form is true and correct.

Ima Confused, Ima Confused, 11/5/18, Printed Name, Signature, Date, Street Address, City, State, Zip Code, Email, Phone Number, WORK/CELL (circle one)

RACIAL/ETHNIC IDENTITY (Optional): Please check appropriate boxes to identify the race and ethnicity of enrolled child(ren). Includes checkboxes for American Indian, Asian, Black, White, Hispanic, etc.

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... If the parent does not fill in the child's ethnic and racial data, the center must fill it out based on visual determination.

Sponsor Use Only

Effective Date of This Enrollment Form: (m/d/yy), Effective Withdrawal Date of This Enrollment Form: (m/d/yy)

Printed Name of Center Representative, Signature of Center Representative, This form is effective for 12 months from the date of parent signature.

Revised July 2017; Previous Versions Obsolete

**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.
<b>SNAP and TANF MUST BE NINE (9) DIGITS</b>						
1	Jimmy Confused			<input checked="" type="checkbox"/>		
2	Ima Confused			<input type="checkbox"/>		7 3 5 2 6 7 8 0 4
3				<input type="checkbox"/>		
4				<input type="checkbox"/>		
5				<input type="checkbox"/>		
6				<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.

NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	GROSS INCOME AND HOW OFTEN IT IS RECEIVED (Example: \$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. Ima Confused	\$ 400	Week	\$		\$		\$	
ii.	\$		\$		\$		\$	
iii.	\$		\$		\$		\$	
iv.	\$		\$		\$		\$	
v.	\$		\$		\$		\$	

6 Social Security Number:           - 4 6 3 2            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

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)  
(Child) Annual Enrollment Form (AEF)**

**CENTER/PROVIDER COMPLETE THIS SECTION**

*Center/Provider Name*

*Street Address*

*City*

**VA**

*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 6 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 Shelters

1	FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	2	DAYS OF WEEK IN ATTENDANCE	3			4	MEALS RECEIVED
				TIMES CHILD NORMALLY ATTENDS CARE DURING THE WEEK	TIME IN	TIME OUT		
	<i>Child's First Name</i>		<input type="checkbox"/> Monday					<input type="checkbox"/> Breakfast
	<i>Child's Last Name</i>		<input type="checkbox"/> Tuesday					<input type="checkbox"/> AM Snack
	<i>Date of Birth (mm/dd/yyyy)</i>		<input type="checkbox"/> Wednesday					<input type="checkbox"/> Lunch
	<i>Age</i>		<input type="checkbox"/> Thursday					<input type="checkbox"/> PM Snack
			<input type="checkbox"/> Friday					<input type="checkbox"/> Supper
			<input type="checkbox"/> Saturday					<input type="checkbox"/> EV Snack
			<input type="checkbox"/> Sunday	NOTES:				

**5**

**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:*

**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](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](mailto:program.intake@usda.gov).

This institution is an equal opportunity provider.

**6**

**Ethnic and Racial Identification: Parent/Guardian to complete. Please select ONE Ethnicity; Please select ONE OR MORE Races**

**ETHNIC IDENTIFICATION**

**Hispanic , Latino or Spanish Origin:** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

**Not Hispanic, Latino or Spanish origin**

**I decline to answer.**

**RACIAL IDENTIFICATION**

**American Indian or Alaskan Native:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains culture identification through tribal affiliation or community attachment (includes Aleuts and Eskimos).

**Black, African American, or Haitian:** A person having origins in any of the black racial groups of Africa.

**Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

**White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

**Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

**I decline to answer.**

**VIRGINIA CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (IEF) FOR CHILD CARE CENTERS and FAMILY DAY CARE 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.					kip to Part 6 if you list a SNAP, TANF or FDIPIR case number.										
					<b>SNAP AND TANF MUST BE NINE (9) DIGITS</b>															
1			<input type="checkbox"/>																	
2			<input type="checkbox"/>																	
3			<input type="checkbox"/>																	
4			<input type="checkbox"/>																	
5			<input type="checkbox"/>																	
6			<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.

X 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 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 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: \_\_\_\_\_

**CHILD CARE 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, FDIPIR     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, audiotope, 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](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](mailto:program.intake@usda.gov).

This institution is an equal opportunity provider.