# The Child and Adult Care Food Program
## Enrollment Form / Income Eligibility Statement for Children

CENTER NAME: ABC Child Care

FISCAL YEAR: 2023

### PART 1 – ENROLLMENT INFORMATION

You must complete ALL five columns of Part 1.

| Name(s) of Enrolled Child(ren) | Date of Birth | Before & After Care | Circle Normal Days of Care / Print Normal Hours of Care | Circle the Meals the Child Normally Receives while in Care |
|---|---|---|---|---|
| Johnny Confused | 9/6/20 | YES (NO) | SUN (MON TUE WED TH FRI) SAT<br>Normal hours 8:30 to 5:45 | (Breakfast) A.M. Snack (Lunch)<br>P.M. Snack (Supper) |
| | | YES NO | SUN MON TUE WED TH FRI SAT<br>Normal hours to | Breakfast A.M. Snack Lunch<br>P.M. Snack Supper |
| | | | SAT | Breakfast A.M. Snack Lunch<br>P.M. Snack Supper |

**Enter the children enrolled in the center here. Enter when your child usually attends and the meals they receive.**

### INCOME ELIGIBILITY INFORMATION Please c

- ☐ A member of my household receives SNAP (formerly Foo … and Part 6.
- ☐ One or more of my children participates in Head Start / Early Head Start at this center. → Please complete Part 3 and Part 6.
- ☐ My household includes one or more foster children → Please complete Part 4 and Part 6.
- ☐ My child(ren) may qualify for Free or Reduced-Price meals based on household income. → Please complete Part 5 and Part 6.
- ☐ My child(ren) will not qualify for Free or Reduced-Price meals. → Please complete Part 6 only.

### PART 2 – HOUSEHOLD MEMBER(S) RECEIVING SNAP and/or TANF BENEFITS

If any household member gets SNAP (Food Stamps) and/or TANF benefits, list the recipient's name, circle the benefit type(s), and give the case number.

| Name of Benefit Recipient | Circle One or Both (if applicable) | SNAP / TANF Case Number **(required—not SSN or EBT #)** |
|---|---|---|
| Ima Confused | (SNAP) TANF | 836112887 |

### PART 3 – CHILD(REN) ENROLLED IN HEAD START

If the enrolled child(ren) participates in Head Start/Early Head Start, write the name(s) below.

| Name of Child | Name of Child | Name of Child |
|---|---|---|
| | | |

**If you receive SNAP or TANF benefits, write your number here. It is 6-9 digits long. You're done! Sign and date the form at the bottom.**

### PART 4 – FOSTER CHILDREN

| Name of Foster Child |
|---|
| |
| |
| |

**Households with foster c** … art 6.
**Households with foster &** … f you did **not** complete Part 2, you must complet… meals. You may include foster child(ren) in Part 5 … child(ren) to qualify for free/reduced-price meals … st report any personal income received by the … you receive from the placement agency to support the foster child(ren). If you completed Part 2, skip Part 5. **All complete Part 6.**

### PART 5 – TOTAL HOUSEHOLD INCOME – *Not required if Part 2 or Part 3 is completed.*

Write how much income **and** how frequently that amount is received: weekly, every two weeks (biweekly), twice a month (semimonthly), once a month (monthly), or annually.

| List Names (First and Last) of **Everyone** In Your Household | Gross Income (before Taxes or Deductions) from Last Month (if none, write "0") | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Earnings From Work Before Deductions | | Alimony, Child Support, Welfare, etc. | | Pensions, Retirement, Social Security, VA, etc. | | Second job or any other income | |
| NAME | INCOME | FREQUENCY | INCOME | FREQUENCY | INCOME | FREQUENCY | INCOME | FREQUENCY |
| 1. Johnny Confused | 0 | | | | | | | |
| 2. Ima Confused | $450 | 2Wks | | | | | | |
| 3. | | | | | | | | |
| 4. | | | | | | | | |
| 5. | | | | | | | | |

**If you do not have a SNAP or TANF number, enter ALL people in your home and how much they make. Change hourly rate to the average paycheck and how often you receive it.**

**Write the last 4-digits of your SS#.**

**That's it! Sign and date the form.**

### PART 6 – CERTIFICATION, SIGNATURE, AND SOCIAL SECURITY NUM

The adult household member who fills out this form must sign below. If Part 5 is completed, the adu… f his/her Social Security Number (SSN), or check "I do not have a Social Security Number." (See Privacy Act Sta… **SN are NOT needed if you have checked "My child(ren) will not qualify for Free/Reduced-Price meals" or if you… Head Start or foster child(ren) only.** **CERTIFICATION:** I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds; that institution official(s) may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

| | | |
|---|---|---|
| Ima Confused<br>PRINTED NAME OF PARENT / GUARDIAN | **(LAST 4 DIGITS ONLY)**: XXX – XX – 4 3 2 7<br>SOCIAL SECURITY NUMBER (SSN) OF PARENT/GUARDIAN | |
| Ima Confused<br>SIGNATURE OF PARENT / GUARDIAN | 8/10/2021<br>DATE | ☐ I do not have a Social Security Number |
| 321 Wembly St. Washington DC 20002<br>STREET ADDRESS, CITY, STATE , ZIP CODE | 202-548-2325<br>DAYTIME PHONE | |

# The Child and Adult Care Food Program
# Enrollment Form / Income Eligibility Statement for Children

**CENTER NAME:** _____ **FISCAL YEAR:** 2023

## PART 1 - ENROLLMENT INFORMATION

You must complete ALL five columns of Part 1.

| Name(s) of Enrolled Child(ren) | Date of Birth | Before & After Care | Circle Normal Days of Care / Print Normal Hours of Care | Circle the Meals the Child Normally Receives while in Care |
|---|---|---|---|---|
| | | YES NO | SUN MON TUE WED TH FRI SAT<br>Normal hours _____ to _____ | Breakfast A.M. Snack Lunch<br>P.M. Snack Supper |
| | | YES NO | SUN MON TUE WED TH FRI SAT<br>Normal hours _____ to _____ | Breakfast A.M. Snack Lunch<br>P.M. Snack Supper |
| | | YES NO | SUN MON TUE WED TH FRI SAT<br>Normal hours _____ to _____ | Breakfast A.M. Snack Lunch<br>P.M. Snack Supper |

## INCOME ELIGIBILITY INFORMATION

Please check all that apply and then fill out the parts specified.

- ☐ A member of my household receives SNAP (formerly Food Stamps) and/or TANF benefits. → Please complete Part 2 and Part 6.
- ☐ One or more of my children participates in Head Start / Early Head Start at this center. → Please complete Part 3 and Part 6.
- ☐ My household includes one or more foster children → Please complete Part 4 and Part 6.
- ☐ My child(ren) may qualify for Free or Reduced-Price meals based on household income. → Please complete Part 5 and Part 6.
- ☐ My child(ren) will not qualify for Free or Reduced-Price meals. → Please complete Part 6 only.

## PART 2 - HOUSEHOLD MEMBER(S) RECEIVING SNAP and/or TANF BENEFITS

If any household member gets SNAP (Food Stamps) and/or TANF benefits, list the recipient's name, circle the benefit type(s), and give the case number.

| Name of Benefit Recipient | Circle One or Both (if applicable) | SNAP / TANF Case Number **(required-not SSN or EBT #)** |
|---|---|---|
| | **SNAP** **TANF** | |

## PART 3 - CHILD(REN) ENROLLED IN HEAD START

If the enrolled child(ren) participates in Head Start/Early Head Start, write the name(s) below.

| Name of Child | Name of Child | Name of Child |
|---|---|---|
| | | |

## PART 4 - FOSTER CHILDREN

| Name of Foster Child |
|---|
| |
| |
| |

**Households with foster children only:** Write the child(ren)'s name(s) here, then skip to Part 6.

**Households with foster & non-foster children:** Write foster child(ren)'s name(s) here. If you did **not** complete Part 2, you must complete Part 5 to qualify non-foster child(ren) for free/reduced-price meals. You may include foster child(ren) in Part 5 with non-foster child(ren). This makes it easier for non-foster child(ren) to qualify for free/reduced-price meals. If you choose to list the foster child(ren) in Part 5, you must report any personal income received by the foster child(ren). You do **not** have to report payments that you receive from the placement agency to support the foster child(ren). If you completed Part 2, skip Part 5. **All complete Part 6.**

## PART 5 - TOTAL HOUSEHOLD INCOME - *Not required if Part 2 or Part 3 is completed.*

Write how much income and how frequently that amount is received : weekly, every two weeks (biweekly), twice a month (semimonthly), once a month (monthly), or annually.

| List Names (First and Last) of **Everyone** In Your Household | Gross Income (before Taxes or Deductions) from Last Month (if none, write "0") | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Earnings From Work Before Deductions | | Alimony, Child Support, Welfare, etc. | | Pensions, Retirement, Social Security, VA, etc. | | Second job or any other income | |
| NAME | INCOME | FREQUENCY | INCOME | FREQUENCY | INCOME | FREQUENCY | INCOME | FREQUENCY |
| 1. | | | | | | | | |
| 2. | | | | | | | | |
| 3. | | | | | | | | |
| 4. | | | | | | | | |
| 5. | | | | | | | | |

## PART 6 - CERTIFICATION, SIGNATURE, AND SOCIAL SECURITY NUMBER (LAST 4 DIGITS)

The adult household member who fills out this form must sign below. If Part 5 is completed, the adult signing the form must provide the **last four (4) digits ONLY** of his/her Social Security Number (SSN), or check "I do not have a Social Security Number." (See Privacy Act Statement on the back of this page.) **The last four digits of your SSN are NOT needed if you have checked "My child(ren) will not qualify for Free/Reduced-Price meals" or if you have listed a TANF or SNAP case number or are applying for Head Start or foster child(ren) only. CERTIFICATION:** I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds; that institution official(s) may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

| **PRINTED NAME OF PARENT / GUARDIAN** | **(LAST 4 DIGITS ONLY):** X X X - XX - _ _ _ _<br>SOCIAL SECURITY NUMBER (SSN) OF PARENT/GUARDIAN |
|---|---|
| **SIGNATURE OF PARENT / GUARDIAN** | **DATE** ☐ I do not have a Social Security Number |
| STREET ADDRESS, CITY, STATE, ZIP CODE | DAYTIME PHONE |

## PART 7 - CIVIL RIGHTS INFORMATION: ENROLLED CHILD(REN)'S ETHNICITY & RACE (OPTIONAL)

Check the ethnic and racial identity of your child(ren).

Ethnicity (mark one ethnic identity):

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more racial identities):

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws, and your response will not affect consideration of your application, and may be protected by the Privacy Act. By providing this information, you will assist us in assuring that this Program is administered without discrimination.

**Non-discrimination Statement:** This explains what to do if you believe you have been treated unfairly. "The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex (including gender identity and sexual orientation), religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, income derived all or in part from any public assistance programs, or protected genetic information in employment or any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete a USDA Program Discrimination Complaint Form, found online at http://ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, DC 20250-9410, by fax at (202) 690-7442, or by email at program.intake@usda.gov. Individuals who are deaf, hard of hearing, or have speech disabilities may contact USDA through the Federal Relay Service at (800) 977-8330 or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

In conjunction, the District of Columbia Human Rights Act, approved December 13, 1977 (DC Law 2-38; DC Official Code §2-1402.11(2006), as amended) prohibits discrimination on the basis of marital status, personal appearance, sexual orientation, gender identity or expression, family responsibilities, familial status, source of income, place of residence or business, genetic information, matriculation, or political affiliation of any individual. Additional protected traits can be found at https://ohr.dc.gov/protectedtraits. To file a complaint alleging discrimination on one of these bases, please contact the District of Columbia's Office of Human Rights at (202) 727-4559 or https://ohr.dc.gov/service/file-complaint.

## PRIVACY ACT STATEMENT

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you list a case number for the Supplemental Nutrition Assistance Program (SNAP) and/or the Temporary Assistance for Needy Families (TANF) Program, submit an application on behalf of a foster child only, or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program. Verification efforts may be carried out through program reviews, audits, and investigations and may include contacting the Child and Family Services Agency to verify foster child status; contacting the Income Maintenance Administration office to confirm receipt of SNAP and/or TANF benefits; contacting employers to determine income; and/or checking the documentation produced by the household member to verify the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

## CENTER USE ONLY - IES CLASSIFICATION

**Reimbursement classification category for foster children**

*Check if one or more foster children are reported on this form:*

- ☐ Free

**Reimbursement classification category for non-foster children**

*Check one classification for all non-foster children reported on this form:*

- ☐ Free (TANF, SNAP, Income Eligible, Head Start)
- ☐ Reduced-price
- ☐ Paid (household income above free or reduced-price level)
- ☐ Paid (incomplete information)

**Total Household Income:**

***If necessary, use the correct income conversion formula before adding incomes reported with different frequencies. Once total monthly income is determined, write "monthly" as the frequency and use the "monthly" column of the Income Eligibility Guidelines.***

*To find monthly income:*

**Weekly income** X 4.33 / **every 2 weeks** X 2.15 / **twice a month** X 2

Total income: $ _____ Frequency: _____

Number of household members: _____

**The institution's Determining Official MUST sign and date the IES to complete it.** Signature of a Verifying Official is recommended.

_____ _____

Signature of Determining Official Date

_____ _____

Signature of Verifying Official Date

**Date child(ren) withdrew or terminated :** _____

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
EDUCATION

# Infant Formula and Food Notification Form

**Infant's Name:** _____ **DOB:** _____

**Child Care Provider:** _____

**To: Parents/Guardians of infants, birth through 11 months old**

Your child's care provider participates in the Child and Adult Care Food Program (CACFP). The CACFP is administrated by the District of Columbia Office of the State Superintendent of Education and is funded by the United States Department of Agriculture (USDA). The CACFP subsidizes the cost of the healthy meals prepared and served to your infant while in care. Your provider follows the USDA Meal Pattern Requirements for Infants (see below), as age-and developmentally-appropriate for your baby.

As a participant in the CACFP, your provider must offer formula and meals to all enrolled infants and children.

| USDA Meal Pattern Requirements For Infants | | | |
|---|---|---|---|
| **Age** | **Breakfast** | **Lunch or Supper** | **Snack** |
| **0 - 5 months** | 4-6 fluid ounces formula *or* breast milk | | 4-6 fluid ounces formula *or* breast milk |
| **6 - 11 months** | 6-8 fluid ounces formula *or* breast milk<br>AND<br>0-2 Tbsp fruit *or* vegetable *or* both<br>AND<br>0-4 Tbsp iron fortified infant cereal, meat, fish, poultry, egg yolk, cooked dry beans or peas;<br>*or* 0-2 oz cheese; *or* 0-4 oz (volume) cottage cheese; *or* 0-4 oz or 1/2 cup of yogurt, or a combination of the above | | 2-4 fluid ounces formula *or* breast milk<br>AND<br>0-2 Tbsp fruit *or* vegetable *or* both<br>AND<br>½ slice bread; *or* 0-2 crackers; *or* 0-4 Tbsp infant cereal or ready-to-eat breakfast cereal |

**PARENT FORMULA REQUEST**

USDA supports and encourages mothers to continue breastfeeding when returning to work or school. *You have the option to breastfeed your infant at the center, bring your own formula or breast milk, or use the provider-supplied formula*. The provider offers the formula listed below.

Name of provider-supplied formula: _____

**Do you accept or decline the formula supplied by your provider?** *(Circle one)* **ACCEPT** **DECLINE**

If you DECLINE, list the brand of formula you will provide, or breast milk, or identify if you will breastfeed on site: _____

**PARENT FOOD REQUEST**

**When your infant is 6 months and/or developmentally ready to eat solid foods, do you accept or decline the provider-supplied food?**

*(Circle one)* **ACCEPT all foods** **DECLINE all foods**

Signature of Parent or Guardian: _____ Date: _____

Printed Name of Parent or Guardian: _____

***Please check the back of this form for the center to know which food items to serve to your baby.***

# First Foods Check-In

**Age of Infant:** _____

## Developmental Readiness Indicators

*Indicators from HealthyChildren.org by the AAP*

| | | |
|---|---|---|
| Can your infant sit up with little or no help? *(in a high chair or feeding seat with good head control)* | Yes: ☐ | No: ☐ |
| Does your infant open her mouth when food comes their way? *(tracking food on a spoon, reaching for food, eager to be fed)* | Yes: ☐ | No: ☐ |
| Can your infant move food from a spoon into their mouth/throat? *(swallow without choking or gagging, little to no dribbling)* | Yes: ☐ | No: ☐ |
| Has your infant doubled their birth weight? *(weighs at least 13 pounds)* | Yes: ☐ | No: ☐ |
| Have you introduced solid foods to your infant? | Yes: ☐ | No: ☐ |

**If yes,** select components and list which food items you have introduced to your infant?

| Components | Check below | Food items introduced |
|---|---|---|
| Iron-fortified infant cereal and/or grains | | |
| Meat/meat alternates | | |
| Fruits | | |
| Vegetables | | |

**If yes,** are there any foods that you do <u>not</u> want the institution to serve your infant? For example: beef, carrots, strawberries.

| Components | Check below | Food items to avoid |
|---|---|---|
| Iron-fortified infant cereal and/or grains | | |
| Meat/meat alternates | | |
| Fruits | | |
| Vegetables | | |

Comments: