Child and Adult Care Food Program Child Enrollment Form

Center Name: ABC Child Care

ENROLLMENT FORM FOR CHILDREN IN CHILD CARE

This document does not have to be completed for children in Emergency Shelters, Outside School Hours, and/or At-Risk programs. It is recommended to have new CACFP Annual Enrollment Forms completed each year during the Household Eligibility Application renewal period. Review completed enrollment form and enter the effective date in lower right hand section.

PARENTS: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents and guardians to complete a CACFP Annual Enrollment Form when enrolling their child(ren) and again every year thereafter. This information will help ensure all children receive appropriate meals during their care.

Please complete all areas to include signing and dating same.

FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FIRST CHILD	☑ MONDAY ☐ TUESDAY ☑ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY	X		8:30		X	5:45			☑ BREAKFAST ☐ A.M. SNACK ☑ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
NAME: Johnny Swenson		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
BIRTH DATE: 8/24/2021		Other:								
AGE: 3 years		**Enrollment Date:** **Withdrawal Date:**								

Signature Janice Swenson — *Signature of Parent or Guardian*

8/18/2021 — *Date*

410-659-2538 — *Telephone Number of Parent or Guardian*

CHILD CARE REPRESENTATIVE USE ONLY: _____ _____

Name of Representative/Signature *Date*

The effective date can be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.

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.

Meal Benefit Application for Child Care Centers

July 1, 2023 - June 30, 2024

For more information, read **Instructions for Completing** or call 855-427-2888

Step 1 — List all enrolled children (if more spaces are required for additional names, attach another sheet of paper).

Children in **Foster Care** and children who meet the [illegible] **or Even Start** are eligible for free meals. If **ALL** children listed are foster, homeless, migrant, runaw[illegible]

Enter the children enrolled in the center here.

First and Last Names of All ENROLLED	Check all that apply:					
	Foster Child	Homeless	Migrant	Runaway	Head Start	Even Start
Johnny Confused						

If you receive SNAP or TANF benefits, write your number here. You're done! Sign and date the form at the bottom.

Step 2 — Do any Household Members (including you) currently participate in the Food Supplement Program (FSP) or Temporary Cash Assistance (TCA)?

Circle One: Yes No

If you answered **NO**, complete Step 3.

If you answered **YES**, provide a case number then go to Step 4

Case Number: 8361128887

Step 3 — Report Income for ALL Household Members (skip this step if you answered 'Yes' to Step 2)

List all Household Members (including yourself) even if they do not receive income. For each Household [illegible] income (before taxes) for each source in whole dollars only. If they do not receive income from any sou[illegible]re certifying (promising) that there is no income to report.

How Often = Weekly, Every 2 W[illegible]

First and Last Names of ALL Household Members	Earnings from Work		[illegible]	
	Income	How Often?		[illegible]?
Johnny Swenson	0			
Janice Swenson	$450	2wks		

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.

Total Household Members (Children and Adults): 02

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member: 4327

Check if No SSN: ☐

Step 4 — Contact Information and Adult Signature

I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that officials may verify (check) the information. I am aware that if I purposely give false information, I may be prosecuted under applicable State and Federal laws. I understand my child's eligibility status may be shared as allowed by law.

Printed Name:	Janice Swenson	Signature:	Janice Swenson
Street Address:	123 Wembly St. Baltimore, MD 21201		
Date:	08/21/2021	Phone #:	410-659-2538

Step 5 — OPTIONAL: Children's Racial and Ethnic Identities

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community.

Ethnicity (Check One):

☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race (Check one or more):

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

DO NOT FILL OUT THIS SECTION. CENTER USE ONLY

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

Total Income (Children and Adults): $ _____

☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly

Eligibility: ☐ Free ☐ Categorically Eligible ☐ Reduced ☐ Paid

Determining Official's Signature: _____ Date: _____

Date Withdrawn: _____

Child and Adult Care Food Program

Child Enrollment Form

Center Name: _____

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		TIME-IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL		
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FIRST NAME	❑ MONDAY ❑ TUESDAY ❑ WEDNESDAY ❑ THURSDAY ❑ FRIDAY ❑ SATURDAY ❑ SUNDAY									❑ BREAKFAST ❑ A.M. SNACK ❑ LUNCH ❑ P.M. SNACK ❑ SUPPER ❑ EVENING SNACK
LAST NAME		❑ Yes ❑ No I work multiple shifts and child(ren) may be in care different days/hours								
BIRTH DATE		Other:								
AGE		**Enrollment Date:**			**Withdrawal Date:**					

Signature

_____ _____ _____

Signature of Parent or Guardian *Date* *Telephone Number of Parent or Guardian*

CHILD CARE REPRESENTATIVE USE ONLY:

_____ _____

Name of Representative/Signature *Date*

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First and Last Names of All ENROLLED	Check all that apply:					
	Foster Child	Homeless	Migrant	Runaway	Head Start Early Head Start	Even Start

Step 2 — **Do any Household Members (including you) currently participate in the Food Supplement Program (FSP) or Temporary Cash Assistance (TCA)? Circle One: Yes No**

If you answered **NO**, complete Step 3.
If you answered **YES**, provide a case number then go to Step 4

Case Number: | | | | | | | | | |

Step 3 — **Report Income for ALL Household Members (skip this step if you answered 'Yes' to Step 2)**

List all Household Members (including yourself) even if they do not receive income. For each Household Member listed, if they receive income, report total gross income (before taxes) for each source in whole dollars only. If they do not receive income from any source, enter '0'. If you enter '0' or leave any fields blank you are certifying (promising) that there is no income to report.

How Often = Weekly, Every 2 Weeks, Monthly, Twice a Month or Yearly

First and Last Names of ALL Household Members	Earnings from Work		Child Support, Alimony, Public Assistance		Pensions, Retirement, Other Income	
	Income	How Often?	Income	How Often?	Income	How Often?

Total Household Members (Children and Adults): | |

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member: | | | |

Check if No SSN: ☐

Step 4 — **Contact Information and Adult Signature**

I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that officials may verify (check) the information. I am aware that if I purposely give false information, I may be prosecuted under applicable State and Federal laws. I understand my child's eligibility status may be shared as allowed by law.

Printed Name:		Signature:	
Street Address:			
Date:		Phone #:	

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