# NEW UPDATE DROP IN

## Institution Name:

Child Food Program of Texas

Agreement Number: 101-0681

## Facility/Provider Name:

Taking Kidz Places 140

**Child and Adult Care Food Program (CACFP) Participant Enrollment Form**

Your day care facility participates in the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). The

enrolled participant will receive nutritious meals and snacks at no cost to you. CACFP needs verification of enrollment for each participant in this facility. Please fill out the parent/guardian section of this form, sign it and return it to the above facility/provider. Provide information for one participant per section. **(In order for the institution to receive reimbursement for meals served/claimed, this form must be completed for each enrolled participant annually.)**

Parent/Guardian Please Complete:

**Participant's (Child) Name:** Date of Birth: Age:

Sex:

Food Allergies:

Male

Female

Yes No

Date participant enrolled in the facility:

If "yes" specify:

**(If the participant cannot be served the CACFP Meal Pattern, a statement from the participant's Health Care Provider must be**

Check Days of Normal Care at facility:

Sunday

Monday Tuesday Wednesday Thursday Friday Saturday

Check meals normally eaten at facility:

Breakfast

AM Snack

Lunch

PM Snack

Supper

Evening Snack

Please list the normal times of arrival and departure (check am or pm): **Arrive:** am pm **Depart:**  am pm RACE OF PARTICIPANT: You are NOT required to answer this question.

White

Black or African American

America Indian/Alaska Native

Asian Native Hawaiian or Other Pacific Islander

ETHNIC IDENTITY: You are NOT required to answer this question.

Hispanic or Latino

**If participant is an infant (0-11 months), please complete this box, Check all applicable choice(s) below:**

This institution/facility offers

formula for infants through CACFP. It is your choice

(To be completed by facility/provider)

whether or not to use this formula based on your infant's needs. Baby foods provided by the institution/facility must be in compliance with the

infant meal pattern as required by 7CFR 226.20.

*Note to parents who are getting formula through the WIC Program: Your baby is eligible to get formula from this child care institution/facility as well as from the WIC Program. It is your decision which formula you want your baby to use when she/he is at child care. If you find you are getting more formula than your baby*

*needs, you may wish to talk with your WIC nutritionist or your child care provider.*

Not Hispanic or Latino

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Please mark your preference (choose all that apply) | Today's Date  Birth - 3 months | | Today's Date  4 - 7 months | | Today's Date  8 - 11 months | |
| I will bring expressed breastmilk for  my infant. |  | |  | |  | |
| I want the provider to provide the  infant formula for my infant. |  | |  | |  | |
| I will bring the infant formula for my infant.  Please list the kind of infant formula  you will bring. |  | |  | |  | |
| According to CACFP requirements, in order to claim meals for reimubursement, the provider must provide infant cereal and other foods when your infant is developmentally ready to accept them. | | Please mark your preference | | Today's Date  4 - 7 months | | Today's Date  8 - 11 months |
| I want the provider to provide the  infant cereal and other foods for my | |  | |  |
| I will bring the infant cereal and/or  other foods for my infant. | |  | |  |

I hereby certify the information given on this sheet is true and correct to the best of my knowledge. I also certify that I was given CACFP Meal Benefits Income Eligibility Form Letter to Household, the WIC information, Building for the Future Flyers, Civil Rights Appeals Procedures.

Parent/Guardian Signature: Date: Print Name:

Address:

Home Telephone Number:

City:

State:

Zip Code:

Date Dropped:

Work Telephone Number: Emergency Telephone Number:

In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination , write USDA Director Office of Adjudication and Compliance , 1400 Independence Avenue SW, Washington, DC 20250-9401 or call (866) 632-9992, (202) 260-1026 or (202) 401-0216 (TDD). This institution is an equal opportunity provider and employer.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Part 1. All Household Members** | | | | | | |
| **Name of Enrolled Child(ren):** | | | | | | |
| **Names of all household members**  (First, Middle Initial, Last) | | | CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT)  \* IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO  PART 5 TO SIGN THIS FORM. | | | CHECK IF NO INCOME |
|  | | |  | | |  |
|  | | |  | | |  |
|  | | |  | | |  |
|  | | |  | | |  |
|  | | |  | | |  |
|  | | |  | | |  |
|  | | |  | | |  |
| **Part 2. Benefits:** If any member of your household receives SNAP, TANF, or FDPIR, provide the name and eligibility number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**  NAME: ELIGIBILITY NUMBER: | | | | | | |
| **Part 3. (Applies only to parents/guardians with children enrolled in a day care home)** If any member of your household receives benefits listed on the enclosed *List of Eligible Federal/State Funded Programs (H1660)*, provide the name of the program and eligibility number: NAME: ELIGIBILITY NUMBER:  Check here if no case number  | | | | | | |
| **Part 4. Total Household Gross Income―You must tell us how much and how often** | | | | | | |
| **A. Name**  (List **only** household members with income) | **B. Gross income and how often it was received**  **Note:** Self-employed report income after expenses in box 1 | | | | | |
| 1. Earnings from work before deductions | 2. Welfare, child support, alimony | | 3. Pensions, retirement, Social Security, SSI, VA benefits | 4. All Other Income | |
| *(Example)*  *Jane Smith* | $200/weekly | $150/twice a month | | $100/monthly | $200/bi-monthly | |
|  | $ / | $ / | | $ / | $ / | |
|  | $ / | $ / | | $ / | $ / | |
|  | $ / | $ / | | $ / | $ / | |
|  | $ / | $ / | | $ / | $ / | |
|  | $ / | $ / | | $ / | $ / | |
| **Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)**  An adult household member must sign this form. **If Part 4 is completed, 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.** (See Privacy Act Statement on the next page.)  *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.*  Sign here: Print name: Date:  Address: Phone Number:  City: State: Zip Code: Last four digits of Social Security Number: \* \* \* - \* \* -  I do not have a Social Security Number | | | | | | |

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| **Part 6. Participant's ethnic and racial identities (optional)** | |
| Mark one ethnic identity: | Mark one or more racial identities: |
| Hispanic or Latino Not Hispanic or Latino | Asian American Indian or Alaska Native  White Native Hawaiian or Other Pacific Islander Black or African American |
| **Part 7. Sharing Information With Other Programs: OPTIONAL**  The above information may be disclosed for the purpose of enrolling children in the Children's Health Insurance Program (CHIP). Parents/guardians are not required to consent to such disclosure and electing not to allow disclosure will not adversely affect a child's eligibility.   **I do elect to allow my household information to be disclosed.**   **I do not elect to allow my household information to be disclosed.** | |
| **Don't fill out this part. This is for official use only.** | |
| Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12  Total Income: Per:  Week,  Every 2 Weeks,  Twice A Month,  Month,  Year Household size: Categorical Eligibility: Date Withdrawn: Eligibility: Free Reduced Denied Tier I Tier II  Reason:  Determining Official's Signature: Date:  Confirming Official's Signature: Date: Follow-up Official's Signature: Date: | |
| **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 apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) eligibility number for the participant or other (FDPIR) identifier 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. | |
| **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 (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 (2) fax: (202) 690-7442; or (3) email: [program.intake@usda.gov.](mailto:program.intake@usda.gov) Office of the Assistant Secretary for Civil Rights  1400 Independence Avenue, SW Washington, D.C. 20250-9410;  This institution is an equal opportunity provider. | |

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