Institution Name: FOOD FOR KIDS, INC Agreement Number:

Facility/Provider Name: Mickey Mouse Happy House-test 7

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

Dear Parent/Guardian,

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: Sally Anne Date of Birth: 05/02/2015 Age: 5y 2m

Sex: ☐ Male ☒ Female Date participant enrolled in the facility: 01/23/2020

Food Allergies: ☐ Yes ☒ No If "yes" specify: ______

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

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:** 8:00 ☒ am ☐ pm **Depart:** 5:00 ☐ am ☒ pm

School Times: **Depart:** ☐ am ☐ pm **Return:** ☐ am ☐ pm

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

This institution/ facility offers Simalac formula for infants through CACFP. It is our 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.

☐ I will use the formula offered by this facilty. I give permission for the formula to be mixed and/or bottles to be prepared for my infant by this facility's staff.

☐ I will not use the formula offered by this facilty.
If not, which formula will you send for your infant? ______
If the formula you provide is a special formula, a medical statement must be submitted.

☐ I will provide breastmilk for my infant.

☐ My infant is four (4) months old and older and is developmentally ready for baby foods. I want the institution/facility to provide the following baby food(s) for my infant, which is/are allowed under 7CFR 226.20 (b)(2)(3)(4).

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.

Parent/Guardian Signature: Sign Here Date: Date Here

Print Name: Carrie Anne

Address: 1235 Blue Ribbon Ct City: Reno State: NV Zip Code: 89503

Home Telephone Number: (775) 888-4949

Work Telephone Number: ______ Check Work Shift: ☐ 1st ☐ 2nd ☐ 3rd ☐ Other (Specify) ______

For Facility/Provider Use Only:

Signature of Facility Representative/Provider: ______ Date: ______

Date the Participant Withdrew: ______

Non-Discrimination Statement: This explains what to do if you believe you have been treated unfairly. 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, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

SAMPLE

Institution Name: FOOD FOR KIDS, INC | Agreement Number:

Facility/Provider Name: Mickey Mouse Happy House-test 7

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

Dear Parent/Guardian,

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Parent/Guardian Please Complete:

Participant's (Child) Name: Ricky Anne | Date of Birth: 02/10/2020 | Age: 0y 9m

Sex: [X] Male [ ] Female | Date participant enrolled in the facility: 06/10/2020

Food Allergies: [ ] Yes [X] No | If "yes" specify: ______

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

Check Days of Normal Care at facility: [ ] Sunday [X] Monday [X] Tuesday [X] Wednesday [X] Thursday [X] Friday [ ] Saturday

Check meals normally eaten at facility: [X] Breakfast [X] AM Snack [X] Lunch [X] PM Snack [X] Supper [X] Evening Snack

Please list the normal times of arrival and departure (check AM or PM) **Arrive:** 8:00 [X] am [ ] pm **Depart:** 5:00 [ ] am [X] pm

School Times: **Depart:** ______ [ ] am [ ] pm **Return:** ______ [ ] am [ ] pm

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

This institution/ facility offers ______ formula for infants through CACFP. It is our 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.

- [X] I will use the formula offered by this facilty. I give permission for the formula to be mixed and/or bottles to be prepared for my infant by this facility's staff.
- [ ] I will not use the formula offered by this facilty. If not, which formula will you send for your infant? ______ If the formula you provide is a special formula, a medical statement must be submitted.
- [ ] I will provide breastmilk for my infant.
- [X] My infant is four (4) months old and older and is developmentally ready for baby foods. I want the institution/facility to provide the following baby food(s) for my infant, which is/are allowed under 7CFR 226.20 (b)(2)(3)(4).

______

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.

Parent/Guardian Signature: ______ Date: ______

Print Name: Carrie Anne

Address: 1235 Blue Ribbon Ct | City: Reno | State: NV | Zip Code: 89503

Home Telephone Number: (775) 888-4949

Work Telephone Number: ______ | Check Work Shift: [ ] 1st [ ] 2nd [ ] 3rd [ ] Other (Specify) ______

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Signature of Facility Representative/Provider: ______ Date: ______

Date the Participant Withdrew: ______

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Parent/Guardian Please Complete:

Participant's (Child) Name: Ima Baby Date of Birth: 05/01/2017 Age: 3y 6m

Sex: ☐ Male ☒ Female Date participant enrolled in the facility: 01/18/2018

Food Allergies: ☐ Yes ☒ No If "yes" specify: ____

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

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:** 7:00 ☒ am ☐ pm **Depart:** 5:00 ☐ am ☒ pm

School Times: **Depart:** ☐ am ☐ pm **Return:** ☐ am ☐ pm

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

This institution/ facility offers ____ formula for infants through CACFP. It is our 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.

☐ I will use the formula offered by this facilty. I give permission for the formula to be mixed and/or bottles to be prepared for my infant by this facility's staff.

☒ I will not use the formula offered by this facilty.
If not, which formula will you send for your infant? ____
If the formula you provide is a special formula, a medical statement must be submitted.

☒ I will provide breastmilk for my infant.

☒ My infant is four (4) months old and older and is developmentally ready for baby foods. I want the institution/facility to provide the following baby food(s) for my infant, which is/are allowed under 7CFR 226.20 (b)(2)(3)(4).

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Parent/Guardian Signature: ____ Date: ____

Print Name: Carrie Anne

Address: 1235 Blue Ribbon Ct City: Reno State: NV Zip Code: 89503

Home Telephone Number: (775) 888-4949

Work Telephone Number: ____ Check Work Shift: ☐ 1st ☐ 2nd ☐ 3rd ☐ Other (Specify) ____

For Facility/Provider Use Only:

Signature of Facility Representative/Provider: ____ Date: ____

Date the Participant Withdrew: ____

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SAMPLE

2020-2021 Child and Adult Care Food Program Meal Benefit Income Eligibility Application

Complete one application per household. Please use a pen (not a pencil). **(Child Care Centers)**

STEP 1 — List ALL Household Members who are infants, children, and students up to and including age 18 (if more spaces are required for additional names, attach another sheet of paper)

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related."

Children in **Foster care** and children who meet the definition of **Homeless, Migrant** or **Runaway** are eligible for free meals. Read **How to Apply for Free and Reduced Price School Meals** for more information.

Child's First Name	MI	Child's Last Name	Age	Enrolled? Yes	Enrolled? No	Foster Child	Homeless, Migrant, Runaway
Sally		Anne		X			
Ricky		Anne		X			
Ima		Baby		X			
Added on children can be hand written							

Check all that apply

STEP 2 — Do any Household Members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR?

If NO > Go to STEP 3. **If YES >** Write a case number here then go to STEP 4 (Do not complete STEP 3)

Case Number: 12345678

Write only one case number in this space.

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

Are you unsure what income to include here?

Flip the page and review the charts titled "Sources of Income" for more information.

The "Sources of Income for Children" chart will help you with the Child Income section.

The "Sources of Income for Adults" chart will help you with the All Adult Household Members section.

A. Child Income

Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here.

Child income	How often? Weekly	Bi-Weekly	2x Month	Monthly
$	○	○	○	○

B. All Adult Household Members (including yourself)

List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any income fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and Last)	Earnings from Work	How often? Weekly	Bi-Weekly	2x Month	Monthly	Public Assistance/ Child Support/Alimony	How often? Weekly	Bi-Weekly	2x Month	Monthly	Pensions/Retirement/ All Other Income	How often? Weekly	Bi-Weekly	2x Month	Monthly
John Doe SR.	$ 2000	X	○	○	○	$ 0	○	○	○	○	$ 0	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○

Total Household Members (Children and Adults) * 02

*** Please ensure this number matches total members listed**

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member X X X - X X - 5 5 5 5

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 determining officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Street Address (if available)	Apt #	City	State	Zip	Daytime Phone and Email (optional)
1234 Mocking Bird Ln		Reno	NV	89503	775-555-5555

Printed name of adult signing the form	Signature of adult	Today's date
John Doe SR.	SIGN HERE	7-14-2020

SAMPLE

INSTRUCTIONS | Sources of Income

Sources of Income for Children

Sources of Child Income	Example(s)
- Earnings from work	- A child has a regular full or part-time job where they earn a salary or wages
- Social Security - Disability Payments - Survivor's Benefits	- A child is blind or disabled and receives Social Security benefits - A Parent is disabled, retired, or deceased, and their child receives Social Security benefits
-Income from person outside the household	- A friend or extended family member regularly gives a child spending money
-Income from any other source	- A child receives regular income from a private pension fund, annuity, or trust

Sources of Income for Adults

Earnings from Work	Public Assistance / Alimony / Child Support	Pensions / Retirement / All Other Income
- Salary, wages, cash bonuses - Net income from self-employment (farm or business) If you are in the U.S. Military: - Basic pay and cash bonuses (do NOT include combat pay, FSSA or privatized housing allowances) - Allowances for off-base housing, food and clothing	- Unemployment benefits - Worker's compensation - Supplemental Security Income (SSI) - Cash assistance from State or local government - Alimony payments - Child support payments - Veteran's benefits - Strike benefits	- Social Security (including railroad retirement and black lung benefits) - Private pensions or disability benefits - Regular income from trusts or estates - Annuities - Investment income - Earned interest - Rental income - Regular cash payments from outside household

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. Responding to this section is optional and does not affect your children's eligibility for free or reduced-price meals.

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

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 your child 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 last four digits of 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) case number or other FDPIR identifier for your child 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 your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

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:

Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil
Rights 1400 Independence Avenue, SW
Washington, D.C. 20250-9410

Fax: (202) 690-7442; or

Email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Do not fill out | 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 ______

How often? ○ Weekly ○ Bi-Weekly ○ 2x Month ○ Monthly

Household Size ______

Categorical Eligibility ☐

Eligibility: ○ Free ○ Reduced ○ Paid

Determining Official's Signature ______ **Date** ______

Confirming Official's Signature ______ **Date** ______

SAMPLE