Child + Adult Care Food Program

Center Name: _____

Phone No: _____

Food Program Enrollment Form

Our center participates in the *Child & Adult Care Food Program* (CACFP) under the guidance of the **Texas Department of Agriculture**. The CACFP helps to ensure that your children are served healthy meals and provides our center assistance with food costs that helps us keep your child's tuition more affordable.

Please complete each section, sign/date at the bottom, and return to our center as soon as possible.

Child (1)

Child's Full Name/ *Nombre y Apellido del Nño*		Child's Date of Birth / *Fecha de Nacimiento*	Enrollment Date / *Fecha de Matriculación*
Times In Care / *Las Horas en Cuidado* **START TIME:** ☐ AM ☐ PM **END TIME:** ☐ AM ☐ PM	**Check the days your child normally attends /** *Los días su niño asiste normalmente* ☐ MON ☐ THUR ☐ TUES ☐ FRI ☐ WED ☐ SAT ☐ SUN	**Check the meals your child normally receives while in care /** *Las comidas su niño recibe normalmente mientras en el cuidado* ☐ BREAKFAST ☐ PM SNACK ☐ AM SNACK ☐ SUPPER ☐ LUNCH ☐ EV SNACK	
For Office Use Only / *SOLO PARA EL USO DE LA AGENCIA*		**Withdrawal Date:**	

Child (2)

Child's Full Name/ *Nombre y Apellido del Nño*		Child's Date of Birth / *Fecha de Nacimiento*	Enrollment Date / *Fecha de Matriculación*
Times In Care / *Las Horas en Cuidado* **START TIME:** ☐ AM ☐ PM **END TIME:** ☐ AM ☐ PM	**Check the days your child normally attends /** *Los días su niño asiste normalmente* ☐ MON ☐ THUR ☐ TUES ☐ FRI ☐ WED ☐ SAT ☐ SUN	**Check the meals your child normally receives while in care /** *Las comidas su niño recibe normalmente mientras en el cuidado* ☐ BREAKFAST ☐ PM SNACK ☐ AM SNACK ☐ SUPPER ☐ LUNCH ☐ EV SNACK	
For Office Use Only / *SOLO PARA EL USO DE LA AGENCIA*		**Withdrawal Date:**	

Signature—Parent or Guardian / *La firma de Padre o Guardián*	**Date of Signature /** *La fecha de Firma*
Parent/Guardian Phone No. / *Número de teléfono*	**Parent/Guardian Email Address /** *Dirección electrónico*

This center's CACFP is operated in accordance with the USDA's policies and does not permit discrimination on the basis of race, color, sex, disability, national origin, age, religion, or political beliefs. Complaints regarding discrimination should be forwarded to the following parties: (1) TDA, Civil Rights Dept., Austin, TX 78714 or (2) USDA, Office of Civil Rights, Washington, DC 20250-9410.

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

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 case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:_____ CASE 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 case number: NAME: _____ CASE 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

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino	☐ Asian	☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ 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) case 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:

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Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

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