Child and Adult Care Food Program
Child Enrollment Form

ENROLLMENT FORM FOR CHILDREN IN CHILD CARE (SAMPLE)

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									☐ EARLY MORNING SNACK ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
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:**									
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**		
	☐ *Same Times as Above*	**AM**	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
SECOND CHILD	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ EARLY MORNING SNACK ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
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:**									
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**		
	☐ *Same Times as Above*	**AM**	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
THIRD CHILD	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ EARLY MORNING SNACK ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
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:**									
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**		
	☐ *Same Times as Above*	**AM**	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
FOURTH CHILD	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ EARLY MORNING SNACK ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
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:**									
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**		
	☐ *Same Times as Above*	**AM**	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
FIFTH CHILD	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ EARLY MORNING SNACK ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
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: Effective Date of This Enrollment Form _____ _____

Name of Representative/Signature *Date*

The effective date may 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.

This portion of the form can be used to capture multi-year annual updates.

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Annual Time Period Covered by Signature: ____________________ **to** ____________________

Signature Parent/Guardian____ **Date** ____________________

Signature Center Administrator/Home Provider____________________________ **Date** ____________________

****

Annual Time Period Covered by Signature: ____________________ **to** ____________________

Signature Parent/Guardian____ **Date** ____________________

Signature Center Administrator/Home Provider____________________________ **Date** ____________________

****

Annual Time Period Covered by Signature: ____________________ **to** ____________________

Signature Parent/Guardian____ **Date** ____________________

Signature Center Administrator/Home Provider____________________________ **Date** ____________________

****

Annual Time Period Covered by Signature: ____________________ **to** ____________________

Signature Parent/Guardian____ **Date** ____________________

Signature Center Administrator/Home Provider____________________________ **Date** ____________________

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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).

USDA is an equal opportunity provider and employer.

Child and Adult Care Food Program
Child Care Center Meal Benefit Income Eligibility Form

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 received [State SNAP], [FDPIR], or [State TANF cash assistance], 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. If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call **[Your center director, Homeless Liaison, Migrant Coordinator at Phone #]** Homeless ☐ Migrant ☐ Runaway ☐

Part 4. Total Household Gross Income—You must tell us how much and how often

	B. Gross income and how often it was received			
A. Name (List **only** household members with income)	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	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 3 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 back of this 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

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	

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: _____ Eligibility: Free_____ Reduced_____ Denied (Paid)_____ Date Withdrawn: _____

Reason for Denied:_____

Temporary: Free_____ Reduced_____ Time Period: _____(expires after _____ days)

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date:_____

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

Household size	Yearly
1	$21,590
2	$29,101
3	$36,612
4	$44,123
5	$51,634
6	$59,145
7	$66,656
8	$74,167
Each additional person:	+$7,511

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: 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."

INCOME ELIGIBILITY GUIDELINES

Effective July 1, 2014 to June 30, 2015

Annual Income

Family Size	Free Meals or Milk (130% of Poverty Guidelines)	Reduced Price Meals (185% of Poverty Guidelines)	Not Eligible for Free or Reduced Price Meals or Milk
One	$0 to $15,171	$15,172 to $21,590	$21,591 and up
Two	$0 to $20,449	$20,450 to $29,101	$29,102 and up
Three	$0 to $25,727	$25,728 to $36,612	$36,613 and up
Four	$0 to $31,005	$31,006 to $44,123	$44,124 and up
Five	$0 to $36,283	$36,284 to $51,634	$51,635 and up
Six	$0 to $41,561	$41,562 to $59,145	$59,146 and up
Seven	$0 to $46,839	$46,840 to $66,656	$66,657 and up
Eight	$0 to $52,117	$52,118 to $74,167	$74,168 and up
For Each Additional Family Member Add:	+$5,278	+$7,511	+$7,512

(Annual, Monthly and Weekly Guidelines are on opposite side)

INCOME ELIGIBILITY GUIDELINES

Effective July 1, 2014 to June 30, 2015

For Free Meals or Free Milk

Family Size	Annual	Once a Month	Twice a Month) (24) pay periods/yr	Every Two Weeks (26) pay periods/yr	Every Week
One	$15,171	$1,265	$ 633	$ 584	$ 292
Two	$20,449	$1,705	$ 853	$ 787	$ 394
Three	$25,727	$2,144	$1,072	$ 990	$ 495
Four	$31,005	$2,584	$1,292	$1,193	$ 597
Five	$36,283	$3,024	$1,512	$1,396	$ 698
Six	$41,561	$3,464	$1,732	$1,599	$ 800
Seven	$46,839	$3,904	$1,952	$1,802	$ 901
Eight	$52,117	$4,344	$2,172	$2,005	$1,003
For Each Additional Family Member Add:	+$5,278	+$440	+$220	+$203	+$102

For Reduced Price Meals

Family Size	Annual	Once a Month	Twice a Month (24) pay periods/yr	Every Two Weeks (26) pay periods/yr	Every Week
One	$21,590	$1,800	$ 900	$ 831	$ 416
Two	$29,101	$2,426	$1,213	$1,120	$ 560
Three	$36,612	$3,051	$1,526	$1,409	$ 705
Four	$44,123	$3,677	$1,839	$1,698	$ 849
Five	$51,634	$4,303	$2,152	$1,986	$ 993
Six	$59,145	$4,929	$2,465	$2,275	$1,138
Seven	$66,656	$5,555	$2,778	$2,564	$1,282
Eight	$74,167	$6,181	$3,091	$2,853	$1,427
For Each Additional Family Member Add:	+$7,511	+$626	+$313	+$289	+$145

Conversion required if there are multiple income sources with more than one frequency, the LEA must annualize all income by multiplying:

- weekly income by 52
- bi-weekly income (received every two weeks) by 26
- semi-monthly income (received twice a month) by 24
- monthly income by 12

(Annual Guidelines on the Opposite side)