Provider's Initial: _____

Date: _____

CHILD CARE FOOD PROGRAM
ENROLLMENT FORM
(To be completed by parent or guardian)

You have chosen a daycare that participates on the USDA Child and Adult Care Food Program (CACFP). It is our goal to assist in providing your child with nutritious meals/snacks. This enrollment information may be verified. The meal times, the meal pattern and the daily menus should be posted and available for parents at all times. If you have questions, or comments, or would like to learn more about the Child and Adult Care Food Program, contact our office.

_____ _____
Name of Day Care Facility Address

_____ _____
Telephone Address

The following information is required by USDA Federal Regulation CFR 226.15(e)(2).

I wish to enroll my child(ren), whose names and enrollment information are given below, in the USDA Child and Adult Care Food Program. I understand this program reimburses day care facilities for serving 3 eligible nutritious, well balanced meals/snacks to eligible enrolled children per day.

My child(ren) will be served the following meals:
(Please Circle) Breakfast AM Snack Lunch PM Snack Other _____

Child(ren) Information (please print)

First Name	Last Name	Age	Birthdate	Hrs of Care	Days of Week (circle)	Gender
			/ /	from to	SAT - SUN M – T – W – TH - FR	M F
			/ /	from to	SAT - SUN M – T – W – TH - FR	M F
			/ /	from to	SAT - SUN M – T – W – TH - FR	M F

Note here any food allergies or special needs your child(ren) have: _____

_____

Doctor's Name: _____ Doctor's Telephone: _____

I understand my child(ren) will receive meals at no extra charge to me when they are in care during any scheduled meal service and receive meals. I understand that the day care facility cannot and will not discriminate for reasons of race, color, national origin, sex, or disability. There is to be no discrimination in admission policy, meal service, or use of facility. Any complaints should be addressed to: USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

In case of emergency, please call: HOME # _____ WORK # _____

Parent Address: _____

Parent Signature: _____ Date: _____

(enroll-2007/updated 020915cd)

AR Children USDA Food Program

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM 2017-2018

Facility Name____

Part 1. CHILDREN

LEGAL NAME OF ENROLLED CHILDREN	AGE	FOSTER CHILD YES - NO	ADDITIONAL HOUSEHOLD CHILDREN	AGE

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.**

CASEHEAD NAME:______________________________ CASE NUMBER: ______________________________

A Case number is not the number found on the EBT card or an individual's Social Security number.

Part 3. If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call [Your School, Homeless Liaison, Migrant Coordinator at Phone #] Homeless ❑ Migrant ❑ Runaway ❑

Part 4. Total Household Gross Income: You must indicate amount & how often: weekly, bi-weekly, 2X month, monthly etc.

Names of all Other Household Members, (except the children above)	Earnings from work before deductions	Welfare, Child Support, Alimony	Pensions, SSI, VA Benefits, Social Security, Retirement	All other income	Check here if No Income
	$ ________ __ Weekly __ Bi-Weekly __ 2XMonth __ Monthly	$ ________ __ Weekly __ Bi-Weekly __ 2XMonth __ Monthly	$ ________ __ Weekly __ Bi-Weekly __ 2XMonth __ Monthly	$ ________ __ Weekly __ Bi-Weekly __ 2XMonth __ Monthly	
	$ ________ __ Weekly __ Bi-Weekly __ 2XMonth __ Monthly	$ ________ __ Weekly __ Bi-Weekly __ 2XMonth __ Monthly	$ ________ __ Weekly __ Bi-Weekly __ 2XMonth __ Monthly	$ ________ __ Weekly __ Bi-Weekly __ 2XMonth __ Monthly	
	$ ________ __ Weekly __ Bi-Weekly __ 2XMonth __ Monthly	$ ________ __ Weekly __ Bi-Weekly __ 2XMonth __ Monthly	$ ________ __ Weekly __ Bi-Weekly __ 2XMonth __ Monthly	$ ________ __ Weekly __ Bi-Weekly __ 2XMonth __ Monthly	
	$ ________ __ Weekly __ Bi-Weekly __ 2XMonth __ Monthly	$ ________ __ Weekly __ Bi-Weekly __ 2XMonth __ Monthly	$ ________ __ Weekly __ Bi-Weekly __ 2XMonth __ Monthly	$ ________ __ Weekly __ Bi-Weekly __ 2XMonth __ 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/her Social Security Number or mark the "I do not have a Social Security Number" box.** (See back)

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: ____________________ **(form valid for one (1) year from this date)**

Address: ______________________________ Phone Number: ____________________

City: ______________________________ State: ______________ Zip Code: ______________

Last four digits of Social Security Number: _*_ _*_ _*_ - _*_ _*_ - __ __ __ __ **(required)** ❑ **I do not have a Social Security Number**

Facility Name: _____ **Child's Name:** _____

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, Bi-Weekly x 26, 2X A Month x 24, Monthly x 12

Total Income: _____ Per: ❑ Week, ❑ Bi-Weekly, ❑ 2X Month, ❑ Monthly, ❑ Year Household size: _____

Categorical Eligibility: _____ Date Withdrawn: _____ Eligibility: Free ____ Reduced ____ Denied ____ Tier I ____ Tier II ____

Reason: _____

Temporary: Free _____ Reduced _____ Time Period: _____(expires after _____ days)

Determining Official's Signature: _____ Date: _____

If applicable, Sponsor Signature: _____ Date: _____

Income Conversion Chart – If Various Payment Methods are Indicated on Front

Weekly: $_____ X 52 = $_____ Total Yearly Income:

Bi-Weekly: $_____ X 26 = $_____ $_____

2X Month: $_____ X 24 = $_____

Monthly: $_____ X 12 = $_____

HNP Representative Initials/Date
(for use during CACFP Reviews)

_____

Household Size	Yearly July 1, 2017 – June 30, 2018	
	Free (Maximum amount)	Reduced (Maximum amount)
1	$15,678	$22,311
2	$21,112	$30,044
3	$26,546	$37,777
4	$31,980	$45,510
5	$37,414	$53,243
6	$42,848	$60,976
7	$48,282	$68,709
8	$53,716	$76,442
Each additional person:	+$5,434	+$7,733

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

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, Assistant Secretary for Civil Rights, 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."

Please send copy of this form to AR Children at P.O. Box 182 Roland, AR 72135
Email – centers@AR-Children.com - Fax 1-501-330-1205