This letter is intended for the parents or guardians of children enrolled at:

Dear Parent/Guardian:

This child care center offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached Meal Benefit Income Eligibility Form. In addition, by filling out this form, we will be able to determine if your child(ren) qualifies for free or reduced price meals.

1. **Do I need to fill out a Meal Benefit Form for each of my children in day care?** You may complete and submit one CACFP Meal Benefit Income Eligibility Form for all children enrolled in child care in your household **only** if the children in child care are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. **Return the completed form to the child care center's director.**

2. **Who can get free meals without providing income information?** Children in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) can get free meals. Foster children (reference question #8 for more information on foster children) and children enrolled in a Head Start Program (HSP), Early Head Start Program (EHSP), or Even Start Program (ESP) and have not entered kindergarten) are also eligible for free meals. Households with children enrolled in a HSP, EHSP or ESP can provide a certification letter from the program of the child's enrollment and do not need to complete the CACFP Meal Benefit Income Eligibility Form.

3. **Who can get reduced price meals?** Your children can get low cost meals if your household income is within the reduced price limits on the Income Chart, sent with this application. Children in households participating in WIC may be eligible for reduced price meals.

4. **May I fill out a form if someone in my household is not a U.S. citizen?** Yes. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center.

5. **Who should I include as members of my household?** You must include everyone in your household (such as grandparents, other relatives, or friends who live with you) who shares income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you.

6. **How do I report income information and changes in employment status?** The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income Chart, the center will receive a higher level of reimbursement. Once properly approved for free or reduced-price benefits, whether through income or by providing a current SNAP, TANF, FDPIR case number, you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the eligibility standards.

7. **What if my income is not always the same?** List the amount that you normally get. For example, if you normally get $1000 each month, but you missed some work last month and only got $900, put down that you get $1000 per month. If you normally get overtime, include it, but not if you only get it sometimes.

8. **What if I have foster children?** Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the Meal Benefit Form, but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children can provide the Texas Department of Family and Protective Services Form 2085FC, *Placement Authorization Foster Care/Residential Care*, to their child's caregiver and do not need to complete the CACFP Meal Benefit Income Eligibility Form.

9. **We are in the military; do we include our housing and supplemental allowances as income?** If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

CACFP STUDENT ENROLLMENT FORM

CM-1500

Center Name

This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals / snacks for your children. Federal CACFP regulations require all parents/guardians to complete a CACFP Enrollment Form when enrolling their child(ren) and review/update enrollment data annually thereafter.

CHILD INFORMATION

Center Enroll Date ☐☐ / ☐☐ / ☐☐☐☐

Child's First Name

Child's Last Name

Child's Birth Date ☐☐ / ☐☐ / ☐☐☐☐

Normal Days in Care
Center's Days of Operation: M T W TH F SA SU

Normal Hours in Care
Center's Hours of Operation: ☐ AM ☐ PM to ☐ AM ☐ PM

Meals/Snacks Child Receives
Meals/Snacks Served at Center: BRK AMS LUN PMS SUP EVS

Ethnic Identity (Check one)
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Racial Identity (Check all that apply)
- ☐ White
- ☐ Black / African American
- ☐ Am. Indian / Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian / Other Pacific Islander

Gender
- ☐ Male
- ☐ Female

SITE / SPONSOR USE ONLY

Withdrawal Date: __/__/__

Re-Enroll Date __/__/__

Center Enroll Date ☐☐ / ☐☐ / ☐☐☐☐

Child's First Name

Child's Last Name

Child's Birth Date ☐☐ / ☐☐ / ☐☐☐☐

Normal Days in Care
Center's Days of Operation: M T W TH F SA SU

Normal Hours in Care
Center's Hours of Operation: ☐ AM ☐ PM to ☐ AM ☐ PM

Meals/Snacks Child Receives
Meals/Snacks Served at Center: BRK AMS LUN PMS SUP EVS

Ethnic Identity (Check one)
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Racial Identity (Check all that apply)
- ☐ White
- ☐ Black / African American
- ☐ Am. Indian / Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian / Other Pacific Islander

Gender
- ☐ Male
- ☐ Female

SITE / SPONSOR USE ONLY

Withdrawal Date: __/__/__

Re-Enroll Date __/__/__

Center Enroll Date ☐☐ / ☐☐ / ☐☐☐☐

Child's First Name

Child's Last Name

Child's Birth Date ☐☐ / ☐☐ / ☐☐☐☐

Normal Days in Care
Center's Days of Operation: M T W TH F SA SU

Normal Hours in Care
Center's Hours of Operation: ☐ AM ☐ PM to ☐ AM ☐ PM

Meals/Snacks Child Receives
Meals/Snacks Served at Center: BRK AMS LUN PMS SUP EVS

Ethnic Identity (Check one)
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Racial Identity (Check all that apply)
- ☐ White
- ☐ Black / African American
- ☐ Am. Indian / Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian / Other Pacific Islander

Gender
- ☐ Male
- ☐ Female

SITE / SPONSOR USE ONLY

Withdrawal Date: __/__/__

Re-Enroll Date __/__/__

PARENT / GUARDIAN INFORMATION

I certify the information on this form is true and correct to the best of my knowledge and that I have received access to WIC and CACFP literature within the last 12 months.

Signature _____ **Date** _____

Parent First Name

Parent Last Name

Cell Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐

This institution is an equal opportunity provider.

SITE / SPONSOR USE ONLY

Center Name

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members

Names of all household members (First, Middle Initial, Last)	CHECK IF ENROLLED CHILD	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 4.**

NAME: ______________________________ ELIGIBILITY NUMBER: _ _ _ _ _ _ _ _ _

*SNAP or TANF number must be the 8 or 9 digit **EDG#** assigned by HHSC.

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 eligibility number ☐

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

B. Gross income and how often it was received
Note: Self-employed report income after expenses in box 1

A. Name (List **only** household members with income)	1. Earnings from work before deductions	Weekly	Every 2 Weeks	2x Month	Monthly	Annually	2. Welfare, child support, alimony	Weekly	Every 2 Weeks	2x Month	Monthly	Annually	3. Pensions, retirement, Social Security, SSI, VA benefits	Weekly	Every 2 Weeks	2x Month	Monthly	Annually	4. All Other Income	Weekly	Every 2 Weeks	2x Month	Monthly	Annually
Example: Jane Smith	$ 200	☑	☐	☐	☐	☐	$ 150	☐	☐	☑	☐	☐	$ 100	☐	☐	☐	☑	☐	$ 100	☐	☐	☑	☐	☐
	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐
	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐
	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐
	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐
	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐

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) 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, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

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

(2) fax: (833) 256-1665 or (202) 690-7442;

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Infant Declaration Form:

Center Name

INSTRUCTIONS TO PARENTS:

Complete BOTH sections on this form. Sign and date where indicated. Submit to child care provider.

Section 1

Infant's Name _____ Birth Date: ____ / ____ / ____

Parent's Name _____

My child is allergic to the following foods:
(A Doctor's note is required for any foods that cannot be substituted within the same food group.)

_____ _____

Section 2

Your child care provider offers the following iron-fortified infant formula(s): _____

Parent Declaration - ***Select only ONE of the following options.***

☐ **CENTER will provide ALL meal components for infant named above.**

or

☐ **PARENT will provide ALL meal components for infant named above.**

or

☐ **BOTH PARENT and CENTER will provide meal components for infant named above, as indicated below.**

		0-5 Months	6-11 Months
○ Center or ○ Parent	will provide Iron Fortified Infant Formula / Breast Milk ○ (Infant Formula Brand Name: _____)	☐	☐
○ Center or ○ Parent	will provide Iron Fortified Infant Cereal		☐
○ Center or ○ Parent	will provide Infant Fruits/Vegetables		☐
○ Center or ○ Parent	will provide Infant Meats		☐
○ Center or ○ Parent	will provide Crusty Bread/Crackers		☐

***** This form must be updated and submitted any time there is a change in Section 2.**

I understand that once my infant child turns 6 months of age, it is my responsibility to notify the child care center director as to any limitations of solid foods that my infant child is not developmentally ready to receive.

_____ (____)_____-_____ _____ / _____ / _____

Parent Signature **Parent Phone Number** **Date**

**Please include your phone number so our CACFP Sponsor can contact you if they have any questions.*

For Sponsor Use Only