

Ohio Department of Education - Office for Child Nutrition
CHILD AND ADULT CARE FOOD PROGRAM
ENROLLMENT FORM

Required Form for use by Child Care Centers and Head Start Programs

CACFP programs exempt from having an enrollment form on file are: Emergency Shelters, Outside-School-Hours, Youth Development & After School At Risk

Instructions for Completion

- All parents/guardians are to complete a separate form for each child enrolled at the child care or Head Start center.
- List the child's name, age, birth date, the days and hours normally in care and the meals normally received while in care.
- If schedule listed will frequently vary due to changes in parent/guardian schedule, check response box below chart.
- If the child comes before and after school, list the hours in care for both the morning and afternoon.
- CACFP Federal regulations 226.15(e) (2) require that an enrollment form be **completed annually** and signed by the child's parent or guardian.

CENTER NAME

CHILD'S NAME

(please print)

AGE

BIRTHDATE

month / day / year

**CHECK THE NORMAL DAYS AND HOURS YOUR CHILD IS IN CARE
AND THE MEALS RECEIVED WHILE IN CARE**

Check (✓) Days Child Normally in Care	List Hours Child Normally in Care				Check (✓) Meals Child Normally Receives while in Care					
	Arrive	Depart	Arrive	Depart	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

☐ Yes, The schedule listed above may frequently vary due to changes in parents/guardians schedule

**SIGNATURE OF
PARENT/GUARDIAN**

DATE

**DAY PHONE
NUMBER**

MAILING ADDRESS:

STREET /APT.

CITY

ZIP CODE

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If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

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).

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

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(rev. 6/21/2013)

CHILD AND ADULT CARE FOOD PROGRAM: CHILD CARE COMPONENT
INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED PRICE MEALS FY 2014 – 2015

FY2014 – FY2015 (7/1/14 – 6/30/15) INSTRUCTIONS: To apply for free and reduced-price meals, read the Household Letter and instructions on backside of this form. Complete application and return to the center. In accordance with the NSLA, information on this application may be disclosed to other Child Nutrition Programs or applicable enforcement agencies. Parents/guardians are not required to consent to this disclosure. *Part 1* is to be completed by all households. *Part 2* is to be used only for a child living in a household receiving Food Assistance or Ohio Works First (OWF) benefits. *Part 3* is only for children NOT receiving Food Assistance or OWF benefits. *Part 4* an adult household member must sign and date form; the last 4 digits of social security number must be listed if *Part 3* is completed. *Part 5* is optional. * Asterisks indicate info that must be completed. Form must be completed annually and is valid for only 12 mo.

CENTER NAME		CHECK IF A FOSTER CHILD (The legal responsibility of a welfare agency or court)	PART 2 – LIST EACH CHILD'S FOOD ASSISTANCE OR OWF CASE NUMBER, IF ANY. A VALID CASE NUMBER CONTAINS 10 OR 12 DIGITS. DO NOT USE SWIPE CARD NUMBER. 600... numbers not valid.		
PART 1 – PRINT INFORMATION FOR ALL CHILDREN ENROLLED AT CENTER			Circle type of benefit: <input type="checkbox"/> FOOD ASSISTANCE or <input type="checkbox"/> OWF		
* NAME OF ENROLLED CHILD(REN)	AGE		BIRTH DATE	CASE NO.	
1.				CASE NO.	
2.				CASE NO.	
3.			CASE NO.		
4.			CASE NO.		

PART 3 – TOTAL HOUSEHOLD SIZE, TOTAL HOUSEHOLD GROSS INCOME AND HOW OFTEN IT WAS RECEIVED: List names of all household members. List all gross income: list how much and how often. If *Part 2* is completed, skip to *Part 4*.

a. LIST NAMES OF ALL HOUSEHOLD MEMBERS INCLUDING CHILDREN LISTED ABOVE IN PART 1	b. CHECK IF NO/ZERO INCOME	c. GROSS INCOME during the last month (amount earned before taxes & other deductions) and HOW OFTEN IT WAS RECEIVED: Weekly, Every 2 Weeks, Twice Per Month, Monthly, Annually			
		1. Earnings from work before deductions	2. Welfare payments, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA	4. All Other Income
EXAMPLE: JANE SMITH	<input type="checkbox"/>	\$ 200 / weekly	\$ 150 / twice month	\$ 100 / monthly	\$ /
1.	<input type="checkbox"/>	\$ /	\$ /	\$ /	\$ /
2.	<input type="checkbox"/>	\$ /	\$ /	\$ /	\$ /
3.	<input type="checkbox"/>	\$ /	\$ /	\$ /	\$ /
4.	<input type="checkbox"/>	\$ /	\$ /	\$ /	\$ /
5.	<input type="checkbox"/>	\$ /	\$ /	\$ /	\$ /
6.	<input type="checkbox"/>	\$ /	\$ /	\$ /	\$ /

PART 4 – SIGNATURE & LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: Adult household member must sign/date form. If *Part 3* is completed, the adult signing the form must also list last 4 digits of his/her Social Security Number or check the "I do not have a Social Security Number" box. I certify that all information on this form is true and correct and that all income is reported. I understand that the center will get Federal Funds based on the information. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, I may be prosecuted.

* SIGNATURE OF ADULT HOUSEHOLD MEMBER	* DATE	* If <i>Part 3</i> is completed, insert last 4 digits of Social Security Number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (check if applicable) <input type="checkbox"/> I do not have a Social Security Number
Print Name:	Daytime Phone Number:	Work Phone Number:
Street / Apt:	City / State / Zip:	County:

PART 5: RACIAL/ETHNIC IDENTITY (Optional): Please check appropriate boxes to identify the race or ethnicity of enrolled child(ren).

<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Other

Please mark one ethnic identity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

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.

State Distribution: 6/20/2014

THIS SECTION TO BE COMPLETED BY CENTER. Note: All information above this section is to be filled in by the parent or guardian.

Complete information below only if qualifying child(ren) by household income from <i>Part 3</i> . Per the total household size, compare total household income to the USDA Income Eligibility Guidelines to determine correct categorization. When income is listed in different frequencies of pay in <i>Part 3</i> , you must convert all income to annual income before determination. Use the following Annual Income Conversion: Weekly x 52, Every 2 Weeks (bi-weekly) x 26, Twice per Month (semi-monthly) x 24, Monthly x 12		Application Categorized as: <input type="checkbox"/> FREE, based on <input type="checkbox"/> Food Assistance/OWF Case No. <input type="checkbox"/> Household Size & Income <input type="checkbox"/> Foster Child <input type="checkbox"/> REDUCED, based on Household Size & Income <input type="checkbox"/> PAID, based on <input type="checkbox"/> Income Too High <input type="checkbox"/> Incomplete <input type="checkbox"/> Invalid case number or information
Total Household Size: _____	Total Household Income: \$ _____ Per: <input type="checkbox"/> Week <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice Per Month <input type="checkbox"/> Month <input type="checkbox"/> Year	

Signature of Sponsor / Center Representative _____ Date Sponsor Categorized _____

Note: If using parent signature date to determine effective/expiration date of all forms, then option must be selected on FY 15 CRRS management plan.

Effective Date
(From the first of month of date categorized by sponsor/center)

Expiration Date
(Valid until last day of month of which form was dated and categorized by sponsor/center one year earlier)

CACFP
INFANT MEALS – PARENT PREFERENCE LETTER

TO: Parents and Guardians of Infants under one year of age

FROM:

Name of Center or Provider	4 the LUV of Children Childcare Center
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TOPIC: Who will provide food for your infant's meals?

Due to participation on the Child and Adult Care Food Program (CACFP), all children enrolled at this child care center or family child care (FCC) home receive meals free of charge. The CACFP is a child nutrition program of the United States Department of Agriculture. Child care centers and family child care homes are reimbursed a meal rate to help with the cost of serving nutritious meals to enrolled children. These centers and FCC homes can be reimbursed daily for up to two meals and one snack served to each enrolled child, including infants. Emergency Shelters can be reimbursed for up to three meals. The meals must meet CACFP meal pattern requirements for children and infants.

To meet CACFP requirements, the center or FCC home is required to **offer** formula and other required infant food to all enrolled infants. The iron fortified infant formula we will provide for infants until they turn one year of age is:

Center or provider to insert the NAME OF FORMULA that they will provide	Similac Adv., Similac Sor, Isomil;, Similac Sen.
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A parent or guardian may decline the formula offered by the center or home and supply the infant's formula themselves. However, when an infant turns one year of age, the center or FCC home will begin to provide milk and the other required food items to meet the meal pattern requirements for toddler age children.

To assist us in your infant formula and food preferences, please complete preferences below by checking one item each in the formula and solid food section.

PARENT OR GUARDIAN: PLEASE CHECK YOUR PREFERENCES FOR FORMULA AND FOOD

Formula or Breast Milk: (check one)

- ☐ I want the center or FCC home provider to provide formula for my infant
- ☐ I will bring iron fortified infant formula for my infant
- ☐ I will bring expressed breast milk for my infant
- ☐ I will come to the center or FCC home to breast feed my infant

Parent/Guardian: List Name of Formula You Will Provide

Solid Food: (check one)

- ☐ I want the center or FCC home to provide solid food for my infant when he/she is developmentally ready for it
- ☐ I will bring solid food for my infant when he/she is developmentally ready for it

***Note: If your feeding preferences change, the center or provider will ask you to complete a new form.**

INFANT'S NAME:	INFANT'S BIRTHDATE:
PARENT/GUARDIAN SIGNATURE:	DATE:

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