Virginia CACFP Annual CACFP Enrollment Form (Child)

CENTER/PROVIDER COMPLETE THIS SECTION

Annandale Play-Care, Inc.

Center/Provider Name

5100-A Ravensworth Rd | Annandale | VA | 22003

Street Address | *City* | *State* | *Zip Code*

This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide nutritious meals for children. Federal CACFP regulations require all parents/guardians to complete and sign a separate annual Enrollment Form per child when enrolling their child(ren) with this provider, and every 12 months thereafter. **The parent or guardian must complete and ensure accuracy of Sections 1 through 5 below**.

This form is required for:	This form is NOT required for:
Child Care Centers, Family Day Care Homes, Licensed Outside School Hours Care Centers	At-Risk Afterschool Centers, Emergency Shelters

1 FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	2 DAYS OF WEEK IN ATTENDANCE	3 TIMES CHILD NORMALLY ATTENDS CARE DURING THE WEEK			4 MEALS RECEIVED
		TIME IN	TIME OUT	SPORADIC SCHEDULE (no set schedule of days)	
_____ *Child's First Name*	☐ Monday				☐ Breakfast
_____ *Child's Last Name*	☐ Tuesday				☐ AM Snack
_____ *Date of Birth (m/d/yy)*	☐ Wednesday				☐ Lunch
_____ *Age*	☐ Thursday				☐ PM Snack
	☐ Friday	**NOTES:**			☐ Supper
	☐ Saturday				☐ EV Snack
	☐ Sunday				

5 Parent/Guardian Signature and Date:

By signing this form, I certify that I am the parent/legal guardian of the child named in Section 1 of this Enrollment Form and that the information contained on this form is true and correct.

_____ *Printed Name*

_____ *Signature*

_____ *Street Address*

_____ *City, State, Zip Code*

_____ *Phone Number WORK/CELL (circle one)*

_____ *Date*

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

☐	American Indian or Alaska Native	☐	Asian	☐	Black or African American
☐	Native Hawaiian or Other Pacific Islander	☐	White	☐	Other

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

NON-DISCRIMINATION STATEMENT: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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: (202) 690-7442; or
3) email: program.intake@usda.gov.

This institution is an equal opportunity provider

Child Care Representative Use Only

Effective Date of This Enrollment Form: _____ *(m/d/yy)*

Effective Withdrawal Date of This Enrollment Form: _____ *(m/d/yy)*

_____ *Printed Name of Center Representative*

_____ *Signature of Center Representative*

The effective date may be retroactive to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.

This form is effective for 12 months from the date of parent signature.

Revised July 2017; Previous Versions Obsolete

VIRGINIA CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS and FAMILY DAY HOMES

1 All Household Members | 2 | 3

NAMES OF ALL HOUSEHOLD MEMBERS [Adults and Children]				FOSTER CHILD	SNAP, TANF or FDPIR CASE #
	First, Middle Initial, Last	Check if **NO** income	Ages of children in care	Skip to Part 6 if all are foster children.	Skip to Part 6 if you list a SNAP, TANF or FDPIR case number. **SNAP and TANF MUST BE NINE (9) DIGITS**
1		☐		☐	
2		☐		☐	
3		☐		☐	
4		☐		☐	
5		☐		☐	
6		☐		☐	

4 Homeless, Migrant, or Runaway

☐ Homeless ☐ Migrant ☐ Runaway

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.

5 Total Household Gross Income (before deductions). You must tell us how much and how often.

NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	GROSS INCOME AND HOW OFTEN IT IS RECEIVED (Example: $100/month, $100/twice a month, $100/every other week, $100/week)							
	Earnings From Work		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Comp, Unemployment, SSI, etc.	
	Amount	**How often?**	**Amount**	**How often?**	**Amount**	**How often?**	**Amount**	**How often?**
i.	$		$		$		$	
ii.	$		$		$		$	
iii.	$		$		$		$	
iv.	$		$		$		$	
v.	$		$		$		$	

6 Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Part 5 is completed or if zero income is listed, 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.

X X X – X X – ___ ___ ___ ___

Social Security Number

☐ **I do not have a social security number.**

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.

Date | *Printed Name of Adult Household Member* | *Signature of Adult Household Member*

7 Contact Information (Optional)

Work Telephone Number (Include Area Code) | *Home Telephone Number (Include Area Code)* | *Home Address (Number, Street, City, State, Zip Code)*

8 Optional - Sharing Information with Virginia's Health Insurance Program for Children (FAMIS)

May we share your information on this application with the *FAMIS*, the complete health insurance program for every child in Virginia? If **yes**, do not sign below.

☐ No, I do not want my information from this application shared with the FAMIS.

Date: _____ Sign here: _____

CHILD CARE REPRESENTATIVE USE ONLY – ELIGIBILITY DETERMINATION – COMPLETE SECTIONS A and B BELOW

SECTION A

Annual Income Conversion: Weekly X 52 Every 2 Weeks X 26 Twice a Month X 24 Once a Month X 12

Convert income only if different frequencies of pay are reported.

TOTAL INCOME Per S_____ ☐ Week ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year **NUMBER IN HOUSEHOLD:** _____

☐ **FREE** based on:			☐ **REDUCED** based	☐ **DENIED** reason:	
☐ foster child	☐ migrant	☐ SNAP or TANF	☐ household income	☐ income too high	☐ incomplete application
☐ homeless	☐ runaway	☐ household income		☐ non-qualifying SNAP/TANF	

SECTION B **Signature of Determining Official:** _____ **Date:** _____