CHILD AND ADULT CARE FOOD PROGRAM
MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care) / FISCAL YEAR 2019
PARENT LETTER

Dear Parent or Guardian:

This center participates in the United States Department of Agriculture Child and Adult Care Food Program (CACFP) and receives federal funds to provide healthy meals and snacks to all of the enrolled children. The amount of reimbursement the center receives is based on the information provided on the attached CACFP Meal Benefit Income Eligibility Form (IEF). Part of the USDA requirement is to complete the IEF. If household income is equal to or less than the income listed in the chart below for household size, the center will receive a higher level of reimbursement. Please return the completed IEF back to our center as soon as possible.

If a member of the family (child or adult) receives Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) or Food Distribution Program on Indian Reservations (FDPIR) benefits or cares for a foster child(ren) that is the legal responsibility of Virginia Department of Social Services or the court, these children are eligible for meal benefits regardless of household income.

If the household income(s) is over the income guidelines listed below, the family is not required to complete this application. Instead, please write the child's name on the IEF and return it to our center. Please notify us if someone in the household becomes unemployed and the loss of income causes the household income to be within the income eligibility standards.

The information provided on the IEF will be used to determine the child's eligibility for meal benefits. The information will be kept confidential and only available to staff directly connected with administering the CACFP.

***Family Access to Medical Insurance Security Plan* (*FAMIS*)**

FAMIS is Virginia's health insurance program for children. It provides access to quality health services for children who do not have health insurance. ***FAMIS Plus*** is Virginia's name for children's Medicaid. ***FAMIS Plus*** also provides great benefits and covers children in families with low or no income, even if the children are covered by health insurance.

By signing the section on the application for *FAMIS* or *FAMIS Plus*, the family is stating they do not want information shared with the local Department of Social Services. If IEF information is disclosed, it may be used to identify the child(ren) for the health insurance program. More information on *FAMIS* is available at 1-866-873-2647 – Interpreters are available. Log onto www.famis.org to apply online.

A household with income less than or equal to the income chart for reduced-priced meals below is eligible for free or reduced-price meals:

Household Size	Yearly
1	$22,459
2	$30,451
3	$38,443
4	$46,435
5	$54,427
6	$62,419
7	$70,411
8	$78,403
Each additional person:	$7,992

Virginia CACFP Annual CACFP Enrollment Form (Child)

CENTER/PROVIDER COMPLETE THIS SECTION

_____

Center/Provider Name

_____ _____ **VA** _____

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*

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:** _____

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 your child for free or reduced-price meals. You must include the last four digits of your 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 or other FDPIR identifier for your child 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 your child is eligible for free or reduced-price meals, and for administration and enforcement of the Child and Adult Care Food Program. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

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(1) mail: U.S. Department of Agriculture

Office of the Assistant Secretary for Civil Rights

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Washington, D.C. 20250-9410;

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

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