Institution Name: Building Better Communities Foundation Agreement Number:

Facility/Provider Name: Kids Place 2 Explore + learn

# Child and Adult Care Food Program (CACFP)
## Participant Enrollment Form

Dear Parent/Guardian,

Your day care facility participates in the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). The enrolled participant will receive nutritious meals and snacks at no cost to you. CACFP needs verification of enrollment for each participant in this facility. Please fill out the parent/guardian section of this form, sign it and return it to the above facility/provider. Provide information for one participant per section. **(In order for the institution to receive reimbursement for meals served/claimed, this form must be completed for each enrolled participant annually.)**

Parent/Guardian Please Complete:

Participant's (Child) Name: _____ Date of Birth: _____ Age: _____

Sex: ☐ Male ☐ Female Date participant enrolled in the facility: _____

Food Allergies: ☐ Yes ☐ No If "yes" specify: _____

**(If the participant cannot be served the CACFP Meal Pattern, a statement from the participant's Health Care Provider must be provided.)**

Check Days of Normal Care at facility: ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Check meals normally eaten at facility: ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

Please list the normal times of arrival and departure (check AM or PM) **Arrive:** _____ am pm **Depart:** _____ ☐ am ☐ pm

School Times: **Depart:** am pm **Return:** ☐ am ☐ pm

**If participant is an infant (0-11 months), please complete this box below, Check all applicable choice(s):**

This institution/ facility offers _____ formula for infants through CACFP. It is our choice
(To be completed by facility/provider)

whether or not to use this formula based on your infant's needs. Baby foods provided by the institution/facility must be in compliance with the infant meal pattern as required by 7CFR 226.20.

☐ I will use the formula offered by this facilty. I give permission for the formula to be mixed and/or bottles to be prepared for my infant by this facility's staff.

☐ I will not use the formula offered by this facilty.
If not, which formula will you send for your infant? _____
If the formula you provide is a special formula, a medical statement must be submitted.

☐ I will provide breastmilk for my infant.

☐ My infant is four (4) months old and older and is developmentally ready for baby foods. I want the institution/facility to provide the following baby food(s) for my infant, which is/are allowed under 7CFR 226.20 (b)(2)(3)(4).

_____

*Note to parents who are getting formula through the WIC Program: Your baby is eligible to get formula from this child care institution/facility as well as from the WIC Program. It is your decision which formula you want your baby to use when she/he is at child care. If you find you are getting more formula than your baby needs, you may wish to talk with your WIC nutritionist or your child care provider.*

Parent/Guardian Signature: _____ Date: _____

Print Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Telephone Number: _____

Work Telephone Number: _____ Check Work Shift: ☐ 1st ☐ 2nd ☐ 3rd ☐ Other (Specify) _____

**For Facility/Provider Use Only:**

Signature of Facility Representative/Provider: _____ Date: _____

Date the Participant Withdrew: _____

**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, Director, Office of Adjudication, 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.

# MEAL BENEFIT FORM FOR CHILDREN

## PROGRAM YEAR _____

Name of Child Care Center: Kids Place 2 Explore + learn

Please read the instructions. If you need help completing this form call: (888) 665-4991

Complete, sign, and return form to: Building Better Communities Foundation

### 1. CHILD INFORMATION

(List names of all children enrolled for care)

Check the box if the child is a foster child (the legal responsibility of a welfare agency or court).

| Last | First | M.I. | If all children are foster children, go to #4 and sign this form. |
|---|---|---|---|
| | | | ☐ |
| | | | ☐ |
| | | | ☐ |
| | | | ☐ |

### 2. BENEFITS

If you are receiving CalFresh, CalWORKs, or Food Distribution Program on Indian Reservations (FDPIR) benefits for your child, list the case number and **do not** complete #3. Go to #4.

| |
|---|
| CalFresh Case #: |
| CalWorks Case #: |
| FDPIR Case #: |

### 3. ALL HOUSEHOLD MEMBERS

Complete this section if you **did not** complete #2. List all household members including children enrolled for care. List all income. Go to #4.

☐ **Check here if this household receives no income.** Go to #4.

| NAMES | GROSS INCOME and how often it was received (e.g. weekly, every 2 weeks, twice a month, monthly, or annually)* | | | |
|---|---|---|---|---|
| NAMES OF ALL HOUSEHOLD MEMBERS (INCLUDE THE CHILDREN LISTED ABOVE) | EARNINGS FROM WORK BEFORE DEDUCTIONS | CHILD SUPPORT ALIMONY | PAYMENTS FROM PENSIONS, RETIREMENT, SOCIAL SECURITY | EARNINGS FROM ANY OTHER INCOME |
| | $ | $ | $ | $ |
| | $ | $ | $ | $ |
| | $ | $ | $ | $ |
| | $ | $ | $ | $ |
| | $ | $ | $ | $ |
| | $ | $ | $ | $ |

*Applicants without income are requested to write a **zero** in the applicable field or mark **no income**. Any income field left blank is a positive indication of no income and certifies that there is no income to report. Applications with blank income fields will be processed as complete.

## 4. LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (SSN) AND SIGNATURE

**(PENALTIES FOR MISREPRESENTATION:** I Certify that all of the above information is true and correct and that the CalFresh, CalWORKS, FDPIR, or other eligible program case number is current, correct, or that all income is reported. I understand that this information is being given for the receipt of federal funds; that agency officials may verify the information on the Meal Benefit Form (MBF) and that the deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.)

| | |
|---|---|
| Printed Name: | |
| Last Four Digits of SSN: | ☐ Check here if no SSN |
| Signature of Adult: | Date: |

**PRIVACY ACT STATEMENT**

The Richard B. Russel National School Lunch Act (NSLA) 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 SSN of the adult household member who signs the application. The last four digits of the SSN are not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP, or CalFresh), Temporary Assistance for Needy Families (TANF, or CalWORKS) Program, or 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 SSN. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for the administration and enforcement of the program.

The last four digits of the SSN may be used to identify the household member in verifying the correctness of the information stated on the form. This may include program reviews, audits and investigations, and may include contacting employers to determine income, contacting a CalFresh, CalWORKs, or FDPIR office to determine current certification for CalFresh, CalWORKs, or FDPIR benefits, contacting the state employment security office to determine the amount of benefits received, and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported. The last four digits of the SSN may also be disclosed to programs as authorized under the NSLA and the Child Nutrition Act, the Comptroller General of the United States, and law enforcement officials for the purpose of investigating violations of certain federal, state, and local education, and health and nutrition programs.

## 5. RACIAL/ETHNIC IDENTITY

You are not required to answer these questions.

| If you choose to do so, please mark one or more of the following racial identities: | | |
|---|---|---|
| ☐ American Indian or Alaskan Native | ☐ Asian | ☐ Black or African American |
| ☐ Native Hawaiian or Other Pacific Islander | | ☐ White |

| Please mark one of the following **ethnic** identities: | |
|---|---|
| ☐ Hispanic or Latino | ☐ Not Hispanic or Latino |