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

A. Name (List **only** household members with income)	**B. Gross income and how often it was received** **Note:** Self-employed report income after expenses in box 1																							
	1. Earnings from work before deductions						2. Welfare, child support, alimony						3. Pensions, retirement, Social Security, SSI, VA benefits						4. All Other Income					
		Weekly	Every 2 Weeks	2x Month	Monthly	Annually		Weekly	Every 2 Weeks	2x Month	Monthly	Annually		Weekly	Every 2 Weeks	2x Month	Monthly	Annually		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 STUDENT ENROLLMENT

CM-1500

MiMi's Creative Kids, LLC participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents or guardians to annually review and make changes to enrollment data.

CHILD INFORMATION

Center Enroll Date / /

Child's First Name

Child's Last Name

Child's Birth Date / /

Normal Days in Care (*Center's Operational Days: M-F): M T W TH F SA SU

Normal Hours in Care (*Center's Hours of Operation: 5:30 AM - 6:30 PM): AM PM AM PM

Meals/Snacks Child Receives (*Meals/Snacks Served at Center: BRK,LUN,PMS): 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 or African American
- American 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 Operational Days: M-F): M T W TH F SA SU

Normal Hours in Care (*Center's Hours of Operation: 5:30 AM - 6:30 PM): AM PM AM PM

Meals/Snacks Child Receives (*Meals/Snacks Served at Center: BRK,LUN,PMS): 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 or African American
- American 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 Operational Days: M-F): M T W TH F SA SU

Normal Hours in Care (*Center's Hours of Operation: 5:30 AM - 6:30 PM): AM PM AM PM

Meals/Snacks Child Receives (*Meals/Snacks Served at Center: BRK,LUN,PMS): BRK AMS LUN PMS SUP EVS

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- Not Hispanic or Latino

Racial Identity (Check all that apply)
- White
- Black or African American
- American 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

SITE / SPONSOR USE ONLY

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/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.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: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

Center Name

MiMi's Creative Kids, LLC

Infant Declaration Form:

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 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

30 Day Solid Foods Infant Waiver (*for 6 – 11 month old infant*):

Child Care Center Name _____

Attention Parent:

- *Please Complete Both Sections and Sign & Date Form*
- *Then Give This Form Back To The Child Care Director*

Infant's Name _____ Birth Date____/____/____

Parent's Name _____

PARENT WAIVER REQUEST:

I have notified the child care center that my 6 – 11 month old infant child is not ready to receive the following meal components:

☐ Iron Fortified Infant Cereal

☐ Infant Fruits/Vegetables

☐ Infant Meats and Meat Alternates

☐ Infant Breads/Grains

Circle the Age Month This Waiver Is For (circle only one month per waiver request)

6th Month 7th Month 8th Month 9th Month 10th Month 11th Month

_____ _____/_____/_____

Parent Signature Date

ATTENTION CENTER/PROVIDER:

1. Have the parent complete this form and sign & data it.
2. Fax this form to your Account Rep upon completion by parent.