Institution Name: Building Better Communities Foundation Agreement Number:

Facility/Provider Name: Just Beginning 84

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: Just Beginning

Please read the instructions. If you need help completing this form, call: (888) 622-0280

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

1. CHILD INFORMATION

List names of all children enrolled for care.

Last Name	First Name	Middle Initial	Foster Child?

2. BENEFITS

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

Program	Case Number
CalFresh	
CalWORKs	
FDPIR	

3. INCOME

Complete this section if you did not complete Setion 2. List all household members including children enrolled for care. List total household gross income and how often it is received (e.g., weekly, every two weeks, twice a month, monthly, or annually).

Check here if this household receives no income.________________________________ Go to Section 4.

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.

Names of all household members, including child(ren) listed above	Earnings from work before deductions	Child support, alimony	Payments from pensions, retirement, Social Security	Earnings from any other income
Example: Janet Smith	$200/weekly	$150/twice a month	$100/monthly	$0
	$	$	$	$
	$	$	$	$
	$	$	$	$
	$	$	$	$
	$	$	$	$

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: ______________________________ **No SSN:** __________

Signature of Parent/Guardian: ______________________________

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 ____________

FOR AGENCY USE ONLY

CATEGORICAL ELIGIBLITY

CalFresh/CalWORKS/FDPIR household categorically eligible? Yes ________ No ________

Foster child automatically eligible free? Yes ________ No ________

INCOME ELIGIBLITY

Annual Conversion (required if household reports various pay frequencies in Section 3): Weekly times (x) 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

Total Household Income and Frequency: $ ____________________ per ________

Household Size ____________

ELIGIBLITY CLASSIFICATION

Eligibility Classification: Free ____________ Reduced-price ____________ Base____________

Determining Official Name: ____________________

Determining Official Signature: ____________________ Date: ________

HOW TO COMPLETE THE MEAL BENEFIT FORM

1. CHILD INFORMATION:

a. Print your child's name.

b. Indicate **yes** to the right of child's name if a foster child.

2. BENEFITS: Complete this section, then skip to Section 4 and sign the form.

a. List your current CalFresh, CalWORKs, or FDPIR case number(s) for your child(ren).

b. Sign the form in Section 4. An adult household member must sign. You do not have to list a SSN.

3. ALL OTHER HOUSEHOLDS: [Complete this section only if you do not have a case number.]

a. Complete this section and sign the form in Section 4. Write the names of everyone in your household even if they do not have an income. Include yourself, your spouse, the child you are applying for, and all other household members. If your household includes any foster children formally placed by a state child welfare agency or a court, you may choose to include the child(ren) in this list.

b. Write the amount of income each person received last month before taxes or anything else was taken out **and** where it came from, such as earnings, pensions, and other income (see examples below for types of income to report). **If you have chosen to include any foster children in your care, only the personal use income is to be listed. Foster payments you receive from the placing agency for the care of the child do not need to be reported.** Each income amount should be entered in the appropriate column on the form. If any amount **last month** was more or less than usual, write that person's usual monthly income.

c. If anyone is self-employed, write the amount of income that person earns from self-employment. Please call the number listed at the top of the form if you need help.

d. Sign the form and include the last four digits of your SSN in Section 4. If you do not have a SSN, place a checkmark next to **No SSN**.

4. LAST FOUR DIGITS OF SSN AND SIGNATURE:

a. The form must have a signature of an adult household member.

b. The adult household member who signs the statement must include the last four digits of his or her SSN. If they do not have an SSN, they will place a checkmark next to the **No SSN** line.

c. The last four digits of the adult household member's SSN is not needed if you listed a CalFresh, CalWORKs, or FDPIR case number is provided.

5. RACIAL/ETHNIC EDENTITY: You are not required to answer this question to get meal benefits, but completion of this information will help ensure that everyone is treated fairly.

INCOME TO REPORT

Earnings from Work

- Wages/salaries/tips
- Strike benefits
- Unemployment compensation
- Worker's compensation
- Net income from self-employment

Child Support/Alimony

- Public assistance payments
- Alimony/child support payments

Pension/Retirement/Social Security

- Pensions
- Supplemental security income
- Retirement income
- Veteran's payments
- Social Security

Other Monthly Income

- Disability benefits
- Cash withdrawn from savings
- Interest dividends
- Income from estates/trusts/investments
- Regular contributions from persons not living in the household
- Net royalties/annuities/net rental income
- Military allowance for off-base housing
- Any other income

DESCRIPTION OF RACIAL AND ETHNIC CATEGORIES

The federal government has established the following five racial categories and one ethnic category:

RACE

American Indian or Alaska Native-A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

Asian-A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, The Philippine Islands, Thailand, and Vietnam.

Black or African American-A person having origins in any of the black racial groups of Africa. Terms such as **Haitian** or **Negro** can be used in addition to **Black or African American**.

Native Hawaiian or Other Pacific Islander-A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White-A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

ETHNICITY

Hispanic or Latino-A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term **Spanish origin** can be used in addition to **Hispanic or Latino**.

Not Hispanic or Latino

U.S. DEPARTMENT OF AGRICULTURE NONDISCRIMINATION 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

3. Email: program.intake@usda.gov

This institution is an equal opportunity provider.