

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

1 All Household Members
2 FOSTER CHILD
3 SNAP, TANF or FDIPIR CASE #
NAMES OF ALL HOUSEHOLD MEMBERS [Adults and Children]
Check if NO income
Date of Birth
Skip to Part 6 if all are foster children.
Skip to Part 6 if you list a SNAP, TANF or FDIPIR case number. MUST BE SEVEN (7) DIGITS

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. (All other income)

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:

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.
NON-DISCRIMINATION STATEMENT: The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program or activity conducted or funded by the Department.

SPONSOR 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: Week Every 2 Weeks Twice a Month Month Year NUMBER IN HOUSEHOLD:
FREE based on: foster child migrant SNAP or TANF homeless runaway household income
REDUCED based on: household income
DENIED reason: income too high incomplete application non-qualifying SNAP/TANF

SECTION B Signature of Determining Official: Date:

Annual Enrollment Form

This form is required for ALL children every 12 months

Center Information – Sponsoring Institutions should pre-fill this section

Center Name

Center Address

City

State

Zip Code

Center or Parent may fill out this section.

1	FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	2	DAYS OF WEEK IN ATTENDANCE	3						4	MEALS RECEIVED											
	_____ <i>Child's First Name</i> _____ <i>Child's Last Name</i> _____ <i>Date of Birth</i> _____ <i>Classroom</i>		<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday	TIME IN (check AM/PM and record time)		TIME OUT (check AM/PM and record time)		TIME CHILD ATTENDS SCHOOL (record in/out times)		<input type="checkbox"/> Breakfast <input type="checkbox"/> AM Snack <input type="checkbox"/> Lunch <input type="checkbox"/> PM Snack <input type="checkbox"/> After School Meal <input type="checkbox"/> Supper <input type="checkbox"/> Evening Snack												
			<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%;">AM</td> <td style="width: 10%;">PM</td> <td style="width: 10%;">Time</td> <td style="width: 10%;">AM</td> <td style="width: 10%;">PM</td> <td style="width: 10%;">Time</td> <td style="width: 10%;">Leaves Center</td> <td style="width: 10%;">Returns To Center</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>	AM	PM	Time	AM	PM	Time		Leaves Center	Returns To Center										
AM	PM	Time	AM	PM	Time	Leaves Center	Returns To Center															
			<input type="checkbox"/> Yes I work multiple shifts and child(ren) may be in care <input type="checkbox"/> No different days/hours.																			

5 Ethnic/Racial Categories

Please answer both questions. This information is voluntary.

A. Ethnic data of child(ren): Mark one only	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino
B. Racial data of child(ren): Mark one or more that apply	<input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native

6 Signature and Date (parent or guardian must complete this section)

I certify the information above is correct.

Parent's Telephone Number (optional)

Signature of Parent or Guardian

Date

Parent's Email

NON-DISCRIMINATION STATEMENT: The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing, or have speech disabilities and wish to file either an EEO or program complaint please contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (in Spanish). USDA is an equal opportunity provider and employer.

Sponsor Representative Use Only

Effective Date of This Enrollment Form: _____

The effective date can be made retroactive back 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.

Signature of Center Representative

Date