

Annual Family CACFP Enrollment Form

Center Name: COMPASS CHILD CARE ISANTI #255										First Day in Care:												
STEP 1 List all children in the	First Name	Last Name	Date of Birth	Enrolled in center?	Foster child?	Hours in Care Arrive Leave		Normal Days in Care M Tu W Th F Sa Su							Normal Meals Received B AM L PM D EV						Ethnicity*	Race**
Ethnicity**Optional to complete H: Hispanic or Latino -OR- N: Not Hispanic or Latino					Race**Optional to complete					I: American Indian or Alaskan Native, A: Asian, B: Black or African American, P: Native Hawaiian or other Pacific Islander, W: White												
STEP 2 Infants	Infant's Name: _____										<input type="checkbox"/> Parent will provide more than 1 food item per meal/snack and decline the CACFP											
	<input type="checkbox"/> Center will provide formula					The type of iron-fortified infant formula this center offers: _____																
	<input type="checkbox"/> Parent will provide breastmilk					<input type="checkbox"/> Parent will provide iron-fortified infant formula. <i>Specify brand & type:</i> _____																
STEP 3	Do any household members currently participate in:			<input type="checkbox"/> SNAP?		<input type="checkbox"/> MFIP?		<input type="checkbox"/> FDPIR?			If YES, Case Number: _____											
STEP 4 Complete if you do not have a case number	Adults – Full Name List all adult household members even if they don't receive income.			Gross Pay		Farm or Self-Employment		Public Assistance, Child Support, Alimony		All Other Incomes												
				How Much?	How Often?	How Much?	How Often?	How Much?	How Often?	How Much?	How Often?											
				\$		\$		\$		\$												
				\$		\$		\$		\$												
				\$		\$		\$		\$												
How Often		W: Weekly, B: Bi-Weekly (every other week), 2: Twice a month, M: Monthly, Y: Yearly						Child Income		\$												
STEP 5	I certify (promise) that all information on this form is true and that all income is reported. I understand this information is given in connection with receipt of federal funds and that officials may check the information. I understand that if I purposely give false information, I may be prosecuted under applicable federal and state laws.																					
	Print Name				Last 4-digits of Social Security Number SSN (if STEP 4 is completed):								No SSN <input type="checkbox"/>									
	Signature			Date		Phone																
	Address				City, State, Zip Code																	
	Email																					

SPONSOR USE ONLY

Free (A) – Foster Free (A) – Case Number Free (A) - Income Reduced (B) - Income Paid (C) **Income:** How Much _____ How Often _____ HH Size _____

6/29/21 Effective Dates _____ TO _____ Signature _____ Date _____ 2nd Approval _____

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FARMER OR SELF-EMPLOYED

Income is your NET income (after deducting business expenses) from farm or self-employment during the year, which is generally shown on Schedule C or F from the federal tax return. A loss from farm or self-employment must be listed as zero income and does not reduce other household income for the purpose of completing this form.

SEASONAL WORKER

Income is your expected AVERAGE GROSS INCOME before deductions (NOT take-home pay) from seasonal work during the year. List your AVERAGE GROSS INCOME from seasonal work per month or other frequency.

PRIVACY ACT STATEMENT / HOW INFORMATION IS USED

The Richard B. Russell National School Lunch Act requires the information on this form. You do not have to give this information but if you do not, we cannot approve your child for free or reduced-price school meals. You must include the last four digits of the Social Security number of the adult household member who signs the application. The last four digits of the Social Security number are not required when you apply on behalf of a foster child, or you provide a Minnesota Family Investment Program (MFIP), Supplemental Nutrition Assistance Program (SNAP) or Food Distribution Program on Indian Reservation (FDPIR) assistance number, or you indicate that the adult household member signing the application does not have a Social Security number.

Only authorized officials will have access to the information you provide on this form. We will use your information to determine if your child qualifies for free or reduced-price meals, and for administration and enforcement of the program. We may share your information with other 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. We require written consent from you before sharing information for other purposes.

While listing your children's race and ethnicity is voluntary, CACFP uses the percentages of participants in each racial and ethnic category to make sure CACFP is operated in a nondiscriminatory manner and in compliance with federal and civil rights laws. The information is not required and will not affect approval of benefits.

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, audiotope, 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.

ABBREVIATIONS

B = Breakfast

AM = AM Snack

L = Lunch

PM = PM Snack

D = Dinner

EV = Evening Snack

SNAP = Supplemental Nutrition Assistance Program

MFIP = Minnesota Family Investment Program

FDPIR = Food Distribution Program on Indian Reservations