

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

1 All Household Members	2	3
NAMES OF ALL HOUSEHOLD MEMBERS [Adults and Children] First, Middle Initial, Last	FOSTER CHILD Skip to Part 6 if all are foster children.	SNAP, TANF or FDIPIR CASE # Skip to Part 6 if you list a SNAP, TANF or FDIPIR case number. MUST BE SEVEN (7) DIGITS
<input type="checkbox"/> Check if NO income	Ages of children at center	
1.	<input type="checkbox"/>	
2.	<input type="checkbox"/>	
3.	<input type="checkbox"/>	
4.	<input type="checkbox"/>	
5.	<input type="checkbox"/>	
6.	<input type="checkbox"/>	

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)	
	Amount	How often?	Amount	How often?	Amount	How often?	Amount	How often?
i.	\$		\$		\$		\$	
ii.	\$		\$		\$		\$	
iii.	\$		\$		\$		\$	
iv.	\$		\$		\$		\$	
v.	\$		\$		\$		\$	

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. The social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program, or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced-price meals, and for administration and enforcement of the Child and Adult Care Food Program. We MAY share your eligibility information with 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.

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.

CHILD CARE 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: <input type="checkbox"/> Week <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Month <input type="checkbox"/> Year	NUMBER IN HOUSEHOLD: _____
<input type="checkbox"/> FREE based on: <input type="checkbox"/> foster child <input type="checkbox"/> migrant <input type="checkbox"/> SNAP or TANF <input type="checkbox"/> homeless <input type="checkbox"/> runaway <input type="checkbox"/> household income		<input type="checkbox"/> REDUCED based on: <input type="checkbox"/> household income
		<input type="checkbox"/> DENIED reason: <input type="checkbox"/> income too high <input type="checkbox"/> incomplete application <input type="checkbox"/> non-qualifying SNAP/TANF

SECTION B Signature of Determining Official: _____ Date: _____

VIRGINIA CACFP INFANT FEEDING PREFERENCE / PARENT CHOICE FORM

Name of Infant _____
(first/last name)

Date of Birth _____
(month/day/year)

This center participates in the Child and Adult Care Food Program (CACFP) and receives USDA reimbursement for serving nutritious meals to infants and children. Participation in this program requires caregivers to follow specific meal patterns according to the age of the child being fed.

_____ will feed your infant breast milk provided by you and/or we will
(name of center)
provide iron fortified infant formula. The formula we provide is: _____

Policy requires a center participating in the CACFP to offer iron fortified formula to infants who are in care during meal service times. Parents/guardians, however, may decline what is offered, and supply the infant's formula.

Please mark your preference (choose all that apply by initialing in the appropriate space)	Today's Date _____ Birth – 3 months	Today's Date _____ 4 – 7 months	Today's Date _____ 8 – 11 months
I will bring expressed breast milk for my infant.			
I will come to the center to breastfeed my infant.			
I want the center to provide formula for my infant			
I will bring formula for my infant. The formula is: _____			

In order to claim meals for reimbursement, the center must provide iron fortified infant cereal and other foods when your baby is developmentally ready for them.

Please mark your preference	Today's Date _____ 4 – 7 months	Today's Date _____ 8 – 11 months
I want the center to provide infant cereal and other foods for my infant based on CACFP guidelines.		
I will bring solid foods for my infant when s/he is ready for it.		

Signature of Parent/Guardian

Date

1. This form must be kept on file for each infant enrolled for child care.
2. As situations change, such as a medical authority changing the infant's formula, a new form should be completed.
3. This form must be kept **current and accurate** for each infant enrolled for child care until the infant reaches one year of age or is no longer on infant formula.
4. If the parent/guardian declines the formula and the provider provides **required** meal and/or snack components, the meal may be claimed for reimbursement.
5. If the parent/guardian declines infant meals/snack, meals and snacks may NOT be claimed for reimbursement.