Special Nutrition Program
Child and Adult Care Food Program
Letter to Parents

Dear Parent/Guardian,

_____ participates in the Child and Adult Care Food Program (CACFP) administered by the United States Department of Agriculture (USDA). Please help us comply with the requirements of the CACFP by completing, signing, and returning the attached statement as soon as possible. This information is necessary so that we may receive CACFP reimbursement for the meals served to children in our program. This form will be placed in our files and treated as confidential information. All children in our program receive their meals free of charge, but the determination of eligibility category affects the amount of Federal funding received by us.

A foster child who is the legal responsibility of a welfare agency or court may be certified as eligible for free meals regardless of your household income. Please contact us for additional information if you have a foster child enrolled in our program.

If you receive food stamps/SNAP, then you need to only list your food stamp case number. In addition, you must complete Section 5 of the form, including all required information with signature, Social Security Number of an adult household member, and date form was completed.

If food stamp/SNAP case number is not reported, you must complete Sections 4 and 5 on the eligibility statement. Section 4 should include the name of **all** household members and the total current household income by source. Section 5 must include all required information with signature, Social Security Number of an adult household member, and date form was completed.

USDA defines a household as a group of related or unrelated individuals (not residents of an institution or boarding house) who are living as one economic unit (i.e., sharing living expenses). The income you report must be last month's total gross household income listed by source, for each household member. If last month's income does not accurately reflect your circumstances, you may provide a projection of your annual income, and you may use last year's income as a basis for making this projection if no significant changes have occurred. If your household's income is equal to or less than the amounts indicated for your household's size on chart below, the center will receive a higher level of reimbursement.

You are required to notify us if there is a change in household size or an increase in income that exceeds $50 per month or $600 per year. If you list a food stamp/SNAP case number, you must notify us when you no longer receive food stamps/SNAP. Similarly, you should notify us if you become unemployed and the loss of income during the period of unemployment causes your family to be within the eligibility standards.

USDA Child Nutrition Program Income Guidelines

Household Size	Weekly Income	Bi-Weekly Income	Twice Monthly Income	Monthly Income	Annual Income
1	$365	729	790	1,580	18,954
2	$493	986	1,069	2,137	25,636
3	$622	1,243	1,347	2,694	32,318
4	$750	1,500	1,625	3,250	39,000
5	$879	1,757	1,904	3,807	45,682
6	$1,007	2,014	2,182	4,364	52,364
7	$1,136	2,271	2,461	4,921	59,046
8	$1,264	2,528	2,739	5,478	65,728
Each additional household member add	+$129	+257	+279	+557	+6,682

This Institution is an equal opportunity employer and provider.

Obligation to Serve Infants in the CACFP

Dear Parents/Guardians:

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

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

Please complete the following information:

Name of Provider/Child Care Center:_____

Type(s) of formula offered:_____

Name of Infant_____

Birth date_____

☐ I accept the type(s) of formula offered by my provider/childcare center/ministry.

☐ I declined the type(s) of formula offered by my provider/childcare center/ministry.

- ☐ I will provide _____formula/breast milk for my infant.
- ☐ I will provide personal breast-feeding of my infant on-site at the facility. Valid beginning October 1, 2017.

☐ I accept the meals and snacks offered by my provider/childcare center/ministry.

☐ I decline the meals and snacks offered by my provider/childcare center/ministry.

I will provide meals and snacks for my infant. Yes☐ No☐

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE

1. This form must be kept on file for each infant enrolled in childcare.
2. As situation 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 childcare 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 meals and/or snack components, the meal may be claimed for reimbursement.
5. If the parent/guardian declines infant meals/snacks, meals and snacks may NOT be claimed for reimbursement.

AR Children
USDA Food Program

Provider's Initial: _____
Date: _____

CHILD CARE FOOD PROGRAM
ENROLLMENT FORM
(to be completed by parent or guardian)

You have chosen a daycare that participates on the USDA Child and Adult Care Food Program (CACFP). It is our goal to assist in providing your child with nutritious meals/snacks. This enrollment information may be verified. The meal times, the meal pattern and the daily menus should be posted and available for parents at all times. If you have questions, or comments, or would like to learn more about the Child and Adult Care Food Program, contact our office.

_____ Name of Day Care Facility

_____ Address

_____ Telephone

_____ Address

The following information is required by USDA Federal Regulation CFR 226.15(e)(2).

I wish to enroll my child(ren), whose names and enrollment information are given below, in the USDA Child and Adult Care Food Program. I understand this program reimburses day care facilities for serving nutritious, well balanced meals/snacks to day care children.

My child(ren) will be served the following meals:
(Please Check) ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Late Snack

Child(ren) Information (please print)

First Name	Last Name	Age	Birthdate	Hrs of Care	Days of Week (check box)	Gender
			/ /	from to	☐M ☐T ☐W ☐Th ☐F ☐Sa	☐ M ☐ F
			/ /	from to	☐M ☐T ☐W ☐Th ☐F ☐Sa	☐ M ☐ F
			/ /	from to	☐M ☐T ☐W ☐Th ☐F ☐Sa	☐ M ☐ F

Note here any food allergies or special needs your child(ren) have: _____

_____

Doctor's Name: _____ Doctor's Telephone: _____

Optional Information: Child(ren)'s racial/ethnic origin
☐Hispanic/Latino ☐Am Indian/Alaskan Native ☐Black/African ☐White ☐Asian ☐Am Native Hawaiian or PI

I understand my child(ren) will receive meals at no extra charge to me when they are in care during any scheduled meal service and receive meals. I understand that the day care facility cannot and will not discriminate for reasons of race, color, national origin, sex, or disability. There is to be no discrimination in admission policy, meal service, or use of facility. Any complaints should be addressed to: USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

In case of emergency, please call: HOME # _____ WORK # _____

Parent Address: _____

Parent Signature: _____ Date: _____
(form valid one (1) year from this date)

(ENR updated 02/22)

AR Children USDA Food Program

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM 2023-2024

Facility Name____

Part 1. CHILDREN

LEGAL NAME OF ENROLLED CHILDREN	AGE	FOSTER CHILD YES - NO	ADDITIONAL HOUSEHOLD CHILDREN	AGE
		☐ ☐		
		☐ ☐		
		☐ ☐		
		☐ ☐		

Part 2. Benefits: If any member of your household received [State SNAP], [FDPIR], or [State TANF cash assistance], provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

CASEHEAD NAME:____________________ CASE NUMBER: ____________________

A Case number is not the number found on the EBT card or an individual's Social Security number.

Part 3. 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 at Phone #] Homeless ☐ Migrant ☐ Runaway ☐

Part 4. Total Household Gross Income: You must indicate amount & how often: weekly, bi-weekly, 2X month, monthly etc.

Names of all Other Household Members, (except the children above)	Earnings from work before deductions	Welfare, Child Support, Alimony	Pensions, SSI, VA Benefits, Social Security, Retirement	All other income	Check here if No Income
	$ ____ ☐Weekly ☐Bi-Weekly ☐2XMonth ☐Monthly	$ ____ ☐Weekly ☐Bi-Weekly ☐2XMonth ☐Monthly	$ ____ ☐Weekly ☐Bi-Weekly ☐2XMonth ☐Monthly	$ ____ ☐Weekly ☐Bi-Weekly ☐2XMonth ☐Monthly	☐
	$ ____ ☐Weekly ☐Bi-Weekly ☐2XMonth ☐Monthly	$ ____ ☐Weekly ☐Bi-Weekly ☐2XMonth ☐Monthly	$ ____ ☐Weekly ☐Bi-Weekly ☐2XMonth ☐Monthly	$ ____ ☐Weekly ☐Bi-Weekly ☐2XMonth ☐Monthly	☐
	$ ____ ☐Weekly ☐Bi-Weekly ☐2XMonth ☐Monthly	$ ____ ☐Weekly ☐Bi-Weekly ☐2XMonth ☐Monthly	$ ____ ☐Weekly ☐Bi-Weekly ☐2XMonth ☐Monthly	$ ____ ☐Weekly ☐Bi-Weekly ☐2XMonth ☐Monthly	☐
	$ ____ ☐Weekly ☐Bi-Weekly ☐2XMonth ☐Monthly	$ ____ ☐Weekly ☐Bi-Weekly ☐2XMonth ☐Monthly	$ ____ ☐Weekly ☐Bi-Weekly ☐2XMonth ☐Monthly	$ ____ ☐Weekly ☐Bi-Weekly ☐2XMonth ☐Monthly	☐

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/her Social Security Number or mark the "I do not have a Social Security Number" box.** (See back)

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: ________________ **(form valid for one (1) year from this date)**

Address: ____________________________ Phone Number: ________________

City:____________________ State: __________ Zip Code: __________

Last four digits of Social Security Number: * * * - * * - _ _ _ _ ☐ **I do not have a Social Security Number**

(required)

Facility Name: _____ **Child's Name:** _____

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino	☐ Asian	☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ White	☐ Native Hawaiian or Other Pacific Islander
	☐ Black or African American	

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Bi-Weekly x 26, 2X A Month x 24, Monthly x 12

Total Income: _____ Per: ☐ Week, ☐ Bi-Weekly, ☐ 2X Month, ☐ Monthly, ☐ Year Household size: _____

Categorical Eligibility: ____ Date Withdrawn: _____ Eligibility: Free ____ Reduced ____ Denied ____

Reason: _____

Determining Official's Signature: _____ Date: _____

If applicable, Sponsor Signature: _____ Date: _____

Income Conversion Chart – If Various Payment Methods are Indicated on Front

Weekly: $_____ X 52 = $_____ Total Yearly Income:

Bi-Weekly: $_____ X 26 = $_____ $_____

2X Month: $_____ X 24 = $_____

Monthly: $_____ X 12 = $_____

HNP Representative Initials/Date
(for use during CACFP Reviews)

_____

Household Size	Yearly July 1, 2023 – June 30, 2024	
	Free (Maximum amount)	Reduced (Maximum amount)
1	$18,954	$26,973
2	$25,636	$36,482
3	$32,318	$45,991
4	$39,000	$55,500
5	$45,682	$65,009
6	$52,364	$74,518
7	$59,046	$84,027
8	$65,728	$93,536
Each additional person:	+$6,682	+$9,509

The participant in the child care facility may qualify for free or reduced price meals if your household income falls within the maximum limits on this chart.

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 the participant for free or reduced price meals. You must include the last four digits of the 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 for the participant or other (FDPIR) identifier 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 the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

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, Assistant Secretary for Civil Rights, 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."

Please send copy of this form to AR Children at 6323 Ranch Drive Suite A Little Rock, AR 72223
Email – centers@AR-Children.com - Fax 1-501-737-8040