Annual Enrollment Form

Child and Adult Care Food Program

This form is required for Child Care Centers, Pre-K, Head Start, Even Start, and Licensed Outside School Hours Programs.
This form is NOT required for At-Risk After-School, License-exempt Outside School Hours, or Emergency Shelters.

Parents/Centers: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents or guardians to complete or review a CACFP Annual Enrollment Form when enrolling their child(ren) and every year thereafter. This information will help ensure all children receive appropriate meals during their care. The parent or center may complete Sections 1 through 4. The parent must review to ensure accuracy; then complete Section 5, sign and date Section 6. If parent does not complete Section 5, center staff should complete to the best of their ability (by observation) and initial the section. The center will review completed enrollment form.

1 FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	2 DAYS OF WEEK IN ATTENDANCE	3 TIMES CHILD NORMALLY ATTENDS DURING WEEK	4 MEALS RECEIVED
First Child Name Birth Date Age	☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday	TIME IN: AM / PM / TIME TIME OUT: AM / PM / TIME TIMES CHILD ATTENDS SCHOOL: Leaves Center / Returns To Center ☐ Yes ☐ No **I work multiple shifts and child(ren) may be in care different days/hours**	☐ Early Morning Snack ☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper ☐ Evening Snack
Second Child Name Birth Date Age	☐ *Same Days as Above* ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday	☐ *Same Times as Child Above* TIME IN: AM / PM / TIME TIME OUT: AM / PM / TIME TIMES CHILD ATTENDS SCHOOL: Leaves Center / Returns To Center ☐ Yes ☐ No **I work multiple shifts and child(ren) may be in care different days/hours**	☐ *Same Meals as Above* ☐ Early Morning Snack ☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper ☐ Evening Snack
Third Child Name Birth Date Age	☐ *Same Days as Above* ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday	☐ *Same Times as Child Above* TIME IN: AM / PM / TIME TIME OUT: AM / PM / TIME TIMES CHILD ATTENDS SCHOOL: Leaves Center / Returns To Center ☐ Yes ☐ No **I work multiple shifts and child(ren) may be in care different days/hours**	☐ *Same Meals as Above* ☐ Early Morning Snack ☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper ☐ Evening Snack

Please answer both questions. This information is voluntary.

5 ETHNIC/RACIAL CATEGORIES—

A. Ethnic data of child(ren) — Mark only one.
☐ Hispanic or Latino ☐ Not Hispanic or Latino

B. Racial data of child(ren) — Mark one or more that apply.
☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ White ☐ American Indian or Alaska Native

6 SIGNATURE
I certify the information above is correct.
Signature of Parent or Guardian ____ *Date* ____ *Telephone Number of Parent or Guardian* ____

CHILD CARE REPRESENTATIVE USE ONLY

Effective Date of this enrollment form: ____

The effective date may be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month in which this form is received.

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; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

HOUSEHOLD ELIGIBILITY APPLICATION FOR CHILD CARE CENTERS
CHILD AND ADULT CARE FOOD PROGRAM

1. All Household Members | **2.** | **3.**

NAMES OF ALL HOUSEHOLD MEMBERS First, Middle Initial, Last	Ages of Children at Center	FOSTER CHILD Foster children are a legal responsibility of DCFS or court. If all are foster children, skip to #6.	SNAP OR TANF CASE NUMBER Skip to Part 6 if you list a SNAP or TANF case number. At least one SNAP/TANF must be provided below.
		☐	__ __ - __ __ __ - __ __ __ - __ __ __ __ __
		☐	__ __ - __ __ __ - __ __ __ - __ __ __ __ __
		☐	__ __ - __ __ __ - __ __ __ - __ __ __ __ __
		☐	__ __ - __ __ __ - __ __ __ - __ __ __ __ __
		☐	__ __ - __ __ __ - __ __ __ - __ __ __ __ __
		☐	__ __ - __ __ __ - __ __ __ - __ __ __ __ __

4. Homeless, Migrant, or Runaway

☐ Homeless ☐ Migrant ☐ Runaway

Signature of School Homeless Liaison or Migrant Coordinator ______ Date ______

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 WAS RECEIVED (Example: $100/month; $100 /twice a month; $100/every other week; $100/week)							
	Earnings From Work (Before Deductions)		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 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 all information on this application is true and all income is reported. I understand the center will get federal funds based on the information I give. I understand the institution, Illinois State Board of Education, or Office of Inspector General, may verify this information on the application. Deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

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 All Kids Insurance Program

May we share your information on this application with the *All Kids Insurance Program*, the complete health insurance program for every child in Illinois? If ***yes***, do not sign below.

☐ No, I do not want my information from this application shared with the *All Kids Insurance Program*.

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 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 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.*

CHILD CARE REPRESENTATIVE USE ONLY—ELIGIBILITY DETERMINATION - COMPLETE SECTIONS A, B and C BELOW

Follow the *Instructions for Institutions to Process Household Eligibility Applications* available at www.isbe.net/nutrition.

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
- ☐ SNAP or TANF
- ☐ homeless
- ☐ migrant
- ☐ runaway
- ☐ household's income

☐ **Reduced based on:**
- ☐ household's income

☐ **Denied—Reason:**
- ☐ income too high
- ☐ incomplete application
- ☐ Non-qualifying SNAP/TANF

SECTION B **Signature of Determining Official** ______ **Date** ______

SECTION C Effective Date of this application: ______

The effective date may be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month in which the child's eligibility is certified.

PRECIOUS MOMENTS CHRISTIAN ACADEMY
2035 MILFORD ROAD
EAST STROUDSBURG, PA 18301

Child Nutrition Programs

PHYSICIAN STATEMENT FOR FOOD SUBSTITUTION

CHILD'S NAME	AGE	DATE

SCHOOL/FACILITY NAME	ADDRESS (Street, City, State, Zip Code)

Parent/Guardian:

This school/facility participates in a federally-funded Child Nutrition Program and any meals, milk, and snacks served must meet program requirements. Reasonable food accommodations must be made when the accommodation requested is due to a disability and supported by a physician's statement. Reasonable food accommodations may be made for children without disabilities who may still have special dietary needs; a medical statement may be required. If you are requesting a meal accommodation or substitution, please ask your physician to complete and sign this form. If you have any questions, please contact ______________________________
Name
at ____.
Telephone (Include Area Code)

PHYSICIAN STATEMENT

1. Does child have a disability according to 7 CFR Part 15d that requires food accommodation? *(Does he/she have a "physical or mental impairment which substantially limits one or more major life activities"?)*

   ☐ No **If no, go to item 2 below.**

   ☐ Yes **If yes, provide the following information and complete items 3, 4, and 5 below.**

   a. What is the disability? ______________________________

   b. What major life activity is affected? ______________________________

   c. How does the disability restrict the diet? ______________________________

2. Child has no disability but requires a special diet. Identify medical problem which restricts the child's diet and complete items 3, 4, and 5 below.

3. List food/type of food to be omitted. For the safety of the child, please be as specific as possible. A menu may also be developed and attached.

4. List food/type of food to be substituted. For the safety of the child, please be as specific as possible. A menu may also be developed and attached.

5. ______________________________ ______________________________
Date *Signature of Physician*

6. ______________________________ ______________________________
Date *Signature of Parent/Guardian*

FOR SCHOOL USE ONLY:

☐ Form received on ______________________________.

☐ Form incomplete. Parent contacted on ______________________________.

☐ Form complete. Accommodation will not be made. ☐ Child does not have a disability ☐ Request not reasonable

☐ Form complete. Accommodations will begin on ______________________________.

______________________________ ______________________________
Date *Signature of Food Service Director/Contact*