Child and Adult Care Food Program Child Enrollment Form
Child Care Centers

Annual enrollment in the Child and Adult Care Food Program (CACFP) is required by federal regulation.

Complete the following information for each child enrolled at the center. Attach additional pages if necessary. Sign, date and return this form to the Child Care Center.

____
CACFP Sponsor Name

____
Name of center where child is in care (if different than CACFP Sponsor)

CHILD INFORMATION

Last Name	First Name	Last Name	First Name
Normal Meals Received in Care		**Normal Meals Received in Care**	
❑ Breakfast ❑ AM Snack ❑ Lunch	❑ PM Snack ❑ Supper ❑ Evening Snack	❑ Breakfast ❑ AM Snack ❑ Lunch	❑ PM Snack ❑ Supper ❑ Evening Snack

Last Name	First Name	Last Name	First Name
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____
Signature of Parent or Legal Guardian

____
Printed Name

Date Signed:

Month	Day	Year

This Institution is an equal opportunity provider.

Oregon Department of Education
255 Capitol St. NE
Salem, OR 97310

Office of the Superintendent
Child Nutrition Programs
(503) 947-5902

Child and Adult Care Food Program (CACFP)

MEDICAL STATEMENT FOR FOOD SUBSTITUTIONS

Return the completed form to the Child Care Provider/Facility

Part I: To be completed by parent, guardian, or adult day care participant, as applicable

Date: ___________ **Participant's Name:** ____

Parent or Guardian's Name (if applicable):____

Child Care Provider/Facility:____

Part II: To be completed by a *Recognized Medical Authority*

Recognized Medical Authorities: Licensed Physicians (MD), Physician's Assistants (PA), Registered Dietitians (RD), Nurse Practitioners (NP), Registered Nurses (RN), Naturopathic Physician (ND), Doctor of Osteopathy (DO), and Naturopathic Doctor of Osteopathy (NDO).

Date: ___________ **Patient/Client's Name:**____

Medical Condition that requires participant to have food substitutions: ______________________

____

____

Food(s) to be omitted from diet:	**Foods to be substituted:**
__________________________________	__________________________________
__________________________________	__________________________________
__________________________________	__________________________________
__________________________________	__________________________________
__________________________________	__________________________________
__________________________________	__________________________________
__________________________________	__________________________________

I certify the above named patient/client requires the food substitutions described above for medical reasons:

Signature of Medical Authority ____

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2012-2013 CONFIDENTIAL INCOME STATEMENT – Child Care Centers/Family Day Care Providers

INSTRUCTIONS:

- If your household received SNAP, TANF or FDPIR, complete parts 1-3, and 5; part 6 is optional.
- If you do not receive these benefits and your income is below the guidelines (back) complete parts 1, 2, 4, and 5; part 6 is optional.
- If you are applying for a FOSTER CHILD only, complete parts 1, 2, and 5; part 6 is optional.

1 HOUSEHOLD INFORMATION

Print name of person completing this application (Last name, First name) ______________________

Name **Print** ______________________

Mailing Address – Apt # ______________________

City State Zip

Home Phone or Cell Phone (Circle One) ______________________

Work Phone ______________________

➔ Number living in this household ________ (Write names of **all** household members on part 2 and/or part 4 of this form)

2 CHILD INFORMATION – (Names of Your Children Enrolled in Child Care)

	Child's Name (Legal Last name, First name)	Birth Date	Age	Check if Foster Child (placed by welfare agency or court) If only foster care child(ren) see instructions above
1.				❑
2.				❑
3.				❑
4.				❑
5.				❑

3 PUBLIC BENEFITS Indicate which **benefits** your household currently receives, and list case number, if any:

Name: ______________________ Case Number: ______________________

☐ SNAP (Supplemental Nutrition Assistance Program) (*Oregon Trail Card number not acceptable*)

☐ TANF (Temporary Assistance to Needy Families) (*Employment Related Day Care does not qualify*)

Does this household receive FDPIR (Food Distribution on Indian Reservations) ☐ Yes

4 HOUSEHOLD MEMBERS & GROSS MONTHLY INCOME – if not monthly, see back for conversions

	Column 1 List **all** household members, including children not attending school, and income. Do not include children listed in part 2, unless they receive regular income. (*Last name, first name*)	Column 2 MONTHLY INCOME (Total earnings & wages before deductions)	Column 3 MONTHLY CHILD SUPPORT, WELFARE, ALIMONY RECEIVED	Column 4 MONTHLY PENSIONS, SOCIAL SEC., RETIREMENT, SSI, VA	Column 5 OTHER MONTHLY INCOME -Including unemployment and workers comp.	Column 6 Check if No Income
1.						❑
2.						❑
3.						❑
4.						❑

5 SIGNATURE, DATE and Last four numbers of SOCIAL SECURITY NUMBER (Adult must sign)

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.

Signature of Adult Household Member X______________________

Date Signed ____________ Month/day/year

Social Security Number (See privacy statement on back) XXX-XX -__ __ __ __

☐ **I do not have a Social Security Number.**

6 RACIAL OR ETHNIC GROUP (OPTIONAL)

Mark one ethnic identity:

☐ Hispanic or Latino
☐ Not Hispanic or Latino

Mark one or more racial identities:

☐ Asian
☐ American Indian & Alaskan Native
☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American
☐ White, not of Hispanic origin
☐ Other

SPONSOR USE ONLY - DO NOT WRITE BELOW THIS LINE

Total Income:__________ Number in Household:________

Centers

Eligibility : ☐Free ☐Reduced Price ☐Above Scale

FDCH

☐Tier 1 ☐Tier 2

Eligibility based on : ☐SNAP/TANF ☐ FDPIR ☐Household Income ☐ Foster Child

Notes:

____

Determining Official's Signature : Date ________ 2nd Check (initial)

DETERMINING MONTHLY INCOME FOR EARNINGS & WAGES

Monthly income for all household members must be reported in Section 4 of this application. Income means any money regularly received from work, child support, alimony, pensions, retirements, social security or any other source. Exclude student/school loans. Money received from a business or farm owned by you should be reported as "net income". *Net Income is defined as the total income left after business and farm operating expenses are subtracted from gross receipts.*

Homeless, migrant and runaway youth are categorically eligible for free meals.

Household members who are not paid monthly should change earnings into monthly income by doing the following:

Household members who are paid every week: Multiply total earnings and wages for one pay period, before deductions, by 52. Then divide by 12. The resulting amount is the total monthly income.

Household members who are paid every 2 weeks: Multiply total earnings and wages for one pay period, before deductions, by 26. Then divide by 12. The resulting amount is the total monthly income.

Household members who are paid twice a month: Multiply total earnings and wages for one pay period, before deductions, by 24 then divide by 12. The resulting amount is the total monthly income.

Household members who are seasonal workers or work less than 12 months: Project annual rate of income to accurately represent actual circumstances then divide by 12. The resulting amount is the projected monthly income.

FEDERAL INCOME GUIDELINES

Your children may qualify at least for reduced price meals if your household income falls within the limits of this chart.

	Reduced Price Meals				
Household Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
-1-	20,665	1,723	862	795	398
-2-	27,991	2,333	1,167	1,077	539
-3-	35,317	2,944	1,472	1,359	680
-4-	42,643	3,554	1,777	1,641	821
-5-	49,969	4,165	2,083	1,922	961
-6-	57,295	4,775	2,388	2,204	1,102
-7-	64,621	5,386	2,693	2,486	1,243
-8-	71,947	5,996	2,998	2,768	1,384
For each additional family member add	7,326	611	306	282	141

PRIVACY STATEMENT - SOCIAL SECURITY NUMBERS and OTHER INFORMATION

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 4 digits of the social security number of the adult household member who signs the application. The last 4 digits of 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 case number or Food Distribution Program on Indian Reservations (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 lunch and breakfast programs. 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. We may share the information on this form with Medicaid or the State Children's Health Insurance Program (SCHIP), unless you tell us not to. The information, if disclosed, will only be used to identify eligible children and seek to enroll them in Medicaid or SCHIP.

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 discrimination on the basis of race, color, national origin, sex, age, or disability." To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call, toll free (866) 632-9992 (Voice). Individual who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay at (800) 877-8339) or (866) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."