Child Enrollment Documentation for Child Care Centers Participating in the Child and Adult Care Food Program (CACFP)

Child Care Centers that participate in the Child and Adult Care Food Program (CACFP) are required to collect annual enrollment information from parents and/or guardians. This requirement applies to all CACFP facilities except adult day care centers, emergency shelters, outside-school-hours care centers and at-risk centers.

The enrollment form must include the following elements per regulations 7 CFR § 226.15(e)(2) and § 226.17(b)(8)):

- Each enrolled child's normal days
- Hours in care
- Meal service received
- Signature of parent or guardian.
- Annual updating of the information.

To document enrollment information, child care centers who participate in the Child and Adult Care Food Program (CACFP) can use the attached sample enrollment form or can modify their own child care enrollment form to include the required elements listed above.

Enrollment forms need to be updated annually by a parent or guardian. If the child's normal days that he/she attends the day care, their hours in care, the meal services they receive and contact information stays the same as what was reported on their original form, the parent or guardian can simply initial and date the form at the bottom. If only a few changes are needed the parent or guardian can simply modify the existing form and initial and date the form at the bottom. If there are significant changes that need to be made have the parent or guardian complete a new form.

If you have any questions about the requirement for collection of enrollment information, please contact Food and Nutrition Services (FNS) at 651-582-8526, 800-366-8922 or email mde.fns@state.mn.us.

Child Enrollment Form—Child and Adult Care Food Program

Dear Parents or Guardians,

Your child care center participates in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP) which ensures healthy meals are served to your children. To meet CACFP requirements specific enrollment information must be collected annually. Please complete this form and return it to your child care center.

Name of the Child Care Center: **Center of Excellence -- People serving People**

_____

Child's First Name	Child's Last Name	Date Of Birth	Beginning Date of Child Care

Schedule	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Enter the normal hours your child is in care*							

Check the meals your child normally receives while in care:

Weekdays	☐ Breakfast	☐ AM Snack	☐ Lunch	☐ PM Snack	☐ Supper	☐ Eve Snack
Weekends	☐ Breakfast	☐ AM Snack	☐ Lunch	☐ PM Snack	☐ Supper	☐ Eve Snack

*(for example, 7:30 a.m. – 5 p.m.; for a split schedule, 7:30 a.m. – 9 a.m. and 12:30 p.m. – 5 p.m.)

Child's First Name	Child's Last Name	Date Of Birth	Beginning Date of Child Care

Schedule	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Enter the normal hours your child is in care*							

Check the meals your child normally receives while in care:

Weekdays	☐ Breakfast	☐ AM Snack	☐ Lunch	☐ PM Snack	☐ Supper	☐ Eve Snack
Weekends	☐ Breakfast	☐ AM Snack	☐ Lunch	☐ PM Snack	☐ Supper	☐ Eve Snack

*(for example, 7:30 a.m. – 5 p.m.; for a split schedule, 7:30 a.m. – 9 a.m. and 12:30 p.m. – 5 p.m.)

Infants Only: Your center is required to offer Iron-Fortified Infant Formula (IFIF). The iron-fortified infant formula this center offers is: _Similac Advance_____. You have the option of providing your own IFIF, providing expressed breastmilk or breastfeed on-site. Please indicate your preference (choose one or more):

☐ I want the center to supply formula for my infant. ☐ I will provide breastmilk for my infant.

☐ I will provide the following formula for my infant: _____ ☐ I will breastfeed my infant at the center.

The center will introduce semi-solid foods to your infant according to the decisions made by you and your infant's doctor.

If there are other children in care, please complete additional forms as needed.

Parent/Guardian Signature: _____Date Signed (form completed annually): _____

Parent/Guardian Name (print): _____Home Phone: _____Work Phone: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Child enrollment information needs updates annually. If the above information is the same, initial and date below.

Initial:							
Date:							

Revised 08/2022

DEPARTMENT OF EDUCATION

Child and Adult Care Food Program – Child Care Centers Household Income Statement – July 2024

1 List all infants, children and students through grade 12 in the household, even if they are not related. If more space is needed, attach another sheet.

Child's First Name	Middle Initial (MI)	Child's Last Name	Birthdate	If yes, fill in one or more circles for each child. **Ethnicity and Race are Optional**							
						Ethnicity	**Race – One or more may be selected**				
				Enrolled at this center?	**Child in Foster Care?**	**Hispanic / Latino?**	**American Indian or Alaskan Native?**	**Asian?**	**Black or African American?**	**Native Hawaiian or other Pacific Islander?**	**White?**
				○	○	○	○	○	○	○	○
				○	○	○	○	○	○	○	○
				○	○	○	○	○	○	○	○
				○	○	○	○	○	○	○	○

2 Do any household members **currently** participate in SNAP, MFIP or FDPIR? **If yes, check which program and write the corresponding case number below: Go on to number 4. If no**, go to number 3. **Note: Child Care Assistance, Medical Assistance, WIC benefits, and PMI numbers do not qualify** under this section 2.

☐ **SNAP** Case number_____ ☐ **MFIP** Case number_____ ☐ **FDPIR** Case number_____

3 Report income for all household members. Skip this step if you answered yes to number 2 or if all participants are children in foster care.

A. Child Income. Include the total income a child earns or receives. Child Income: _____ ○ Weekly ○ Every two weeks ○ Twice per Month ○ Monthly

B. Adult Income. Include yourself and record total income below. List all adult household members even if they don't receive income.

Adults – Full Name List the full name of each household member who is living with you and shares income and expenses. Enter all income(s) in whole dollars. If zero income write 0. Include any college students temporarily away.	**Gross Pay from Work** Do not write in an hourly wage						**Farm or Self-Employment**	**Public Assistance, Child Support, Alimony**					**All Other Incomes**				
	Gross pay before taxes (not take-home pay)	Weekly	Every two weeks	Twice per month	Monthly	Annual	Net Income after business expenses. State if annual or monthly.	Payments received	Weekly	Every two weeks	Twice per month	Monthly	Pension, retirement, disability, unemployment, Veterans benefits, etc.	Weekly	Every two weeks	Twice per month	Monthly
	$	○	○	○	○	○	$	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	○	$	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	○	$	$	○	○	○	○	$	○	○	○	○

C. Last four digits of signer's Social Security Number (SSN) or no SSN (required): X X X–X X–☐☐☐☐ or ☐ I don't have an SSN.

4 I certify (promise) that all information on this application is true and correct and all household members and incomes are reported. I understand that this information is given in connection with receipt of federal funds and that officials may verify (check) the information. I understand that if I purposely give false information, I may be prosecuted under applicable federal and state laws.

Signature of adult household member (required): _____ Printed Name: _____ Date: _____

Sponsor Use Only—Do Not Write Below

Approved: ☐ A—Foster ☐ A—Case Number ☐ A—Income ☐ B—Income ☐ C Total Household Members: _____ Total Income: $_____ per _____

Effective Dates: From _____ through _____ Sponsor Signature _____ Date _____

DEPARTMENT OF EDUCATION

Child and Adult Care Food Program – Child Care Centers Household Income Statement – July 2024

Farmer or Self-Employed

Income is your *net* income (after deducting business expenses) from farm or self-employment during the year, which is 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 child in foster care, 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, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and teletypewriter [TTY]) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992 or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or 2. **fax:** (833) 256-1665 or (202) 690-7442; or 3. **Email:** program.intake@usda.gov

This institution is an equal opportunity provider.

Office Use Only: Verification (Pricing Program Only)

Date Verification Sent: _____ Response Due: _____ Second Notice: _____ Result: O No Change O A to B O A to C O B to A O B to C

Reason for change: O Income O Case number not verified O Foster status not verified O Refused cooperation O Other: _____

Signature of verifying official: _____ Date: _____