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

Center Name Dawning Point-Stafford

1 All Household Members

	NAMES OF ALL HOUSEHOLD MEMBERS [Adults and Children] First, Middle Initial, Last	Check if NO income	Ages of children in care	2 FOSTER CHILD Skip to Part 6 if all are foster children.	3 SNAP, TANF or FDPIR CASE # Skip to Part 6 if you list a SNAP, TANF or FDPIR case number. SNAP and TANF MUST BE NINE (9) DIGITS
1.		☐		☐	
2.		☐		☐	
3.		☐		☐	
4.		☐		☐	
5.		☐		☐	
6.		☐		☐	

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.	
	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 _____

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 $_____ ☐ Week ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year **NUMBER IN HOUSEHOLD:**_____

☐ **FREE** based on:	☐ **REDUCED** based on:	☐ **DENIED** Reason:
☐ foster child ☐ migrant ☐ SNAP, TANF, FDPIR ☐ homeless ☐ runaway ☐ household income	☐ household income	☐ income too high ☐ incomplete application ☐ non-qualifying SNAP/TANF

SECTION B

Signature of Determining Official: _____ **Date:** _____

Nondiscrimination statement: 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.

Virginia Child and Audit Care Food Program (CACFP)
Annual Enrollment Form (Child)

CENTER/PROVIDER COMPLETE THIS SECTION

Dawning Point-Stafford

Center/Provider Name

15 Kingsland Dr.	Stafford	VA	225561347
Street Address	*City*	*State*	*Zip Code*

This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide nutritious meals for children. Federal CACFP regulations require all parents/guardians to complete and sign a separate annual Enrollment Form per child when enrolling their child(ren) with this provider, and every 12 months thereafter. **The parent or guardian must complete and ensure accuracy of Sections 1 through 5 below.**

This form is required for:	**This form is NOT required for:**
Child Care Centers, Family Day Care Homes	Outside School Hours Care Centers, Emergency Shelter

1 FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)

Child's First Name

Child's Last Name

Date of Birth (mm/dd/yyyy)

Age

2 DAYS OF WEEK IN ATTENDANCE

- ☐ Monday
- ☐ Tuesday
- ☐ Wednesday
- ☐ Thursday
- ☐ Friday
- ☐ Saturday
- ☐ Sunday

3 TIMES CHILD NORMALLY ATTENDS CARE DURING WEEK

TIME IN	TIME OUT	SPORADIC SCHEDULE (not set schedule of days)

NOTES:

4 MEALS RECEIVED

- ☐ Breakfast
- ☐ AM Snack
- ☐ Lunch
- ☐ PM Snack
- ☐ Supper
- ☐ EV Snack

5 Parent/Guardian Signature and Date:

By signing this form, I certify that I am the parent/legal guardian of the child named in Section 1 of this Enrollment Form and that the information contained on this form is true and correct.

Printed Name:	*Signature:*
Street Address:	*City, State, Zip Code:*
Phone Number WORK / CELL (circle one):	*Date:*

Nondiscrimination statement: 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.

Child Care Representative Use Only

Effective Date of This Enrollment Form:	***The effective date may be retroactive to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.***
(mm/dd/yyyy)	
Effective Withdrawal Date of This Enrollment Form:	
(mm/dd/yyyy)	
Printed Name of Center Representative	*This form is effective for 12 months from the date of parent signature.*
Signature of Center Representative	

VIRGINIA CACFP
Child and Adult Care Food Program

PARENT/GUARDIAN CHOICE FORM (INFANT)

NAME OF INFANT:	_____ *(First Name, Middle Initial, Last Name)*	DATE OF BIRTH:	_____ *(mm/dd/yyyy)*

This center/provider participates in the Child and Adult Care Food Program (CACFP) and receives Federal USDA funding for serving nutritious meals to infants and children. Participation in the CACFP requires caregivers to follow specific meal patterns according to age group classifications detailed in forms *CACFP-009 Child Meal Pattern* and *CACFP-010 Infant Meal Pattern.*

(Center/Provider) Dawning Point-Stafford agrees to feed your infant breast milk provided by parent/guardian. The center/provider will provide iron-fortified infant formula. The formula provider is _____

Federal regulations require centers/providers participating in the CACFP to offer iron-fortified formula to infants who are in care during meal service times. Parents/guardians may decline the center/provider offered formula and supply the infant's formula, provide expressed breastmilk, or breastfeed on site.

PLEASE INDICATE PREFERENCES *(Choose all options that apply by initialing and dating in the appropriate space(s))*	**BIRTH - 5 MONTHS**	**6 MONTHS - 11 MONTHS**
OPTION 1: CENTER/PROVIDER OFFERED IRON-FORTIFIED FORMULA	INITIALS: DATE: _____	INITIALS: DATE: _____
OPTION 2: PARENT/GUARDIAN WILL PROVIDE FORMULA	INITIALS: DATE: _____	INITIALS: DATE: _____
OPTION 3: PARENT/GUARDIAN WILL PROVIDE EXPRESSED BREASTMILK	INITIALS: DATE: _____	INITIALS: DATE: _____
OPTION 4: BREASTFEEDING WILL OCCUR ON SITE	INITIALS: DATE: _____	INITIALS: DATE: _____

BREASTFEEDING FRIENDLY CENTERS/PROVIDERS ARE ENCOURAGED!

Many centers and providers now have designated space onsite for breastfeeding.

Ask your center representative or day care home provider for details!

Federal regulations also require centers/providers participating in the CACFP to provide iron-fortified infant cereal and other foods when the child is developmentally ready.

PLEASE INDICATE PREFERENCES	**BIRTH - 5 MONTHS**	**6 MONTHS - 11 MONTHS**
OPTION 1: CENTER/PROVIDER OFFERED IRON-FORTIFIED CEREAL AND OTHER FOODS BASED ON THE CACFP MEAL	INITIALS: DATE: _____	INITIALS: DATE: _____
OPTION 2: PARENT/GUARDIAN WILL PROVIDE CEREAL AND SOLID FOODS WHEN THE TIME IS APPROPRIATE	INITIALS: DATE: _____	INITIALS: DATE: _____

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

1. THIS FORM MUST BE KEPT **CURRENT, ACCURATE AND ON FILE** FOR EACH INFANT ENROLLED IN CHILD CARE UNTIL THE INFANT REACHES 1 YEAR OF AGE OR IS NO LONGER ON BREASTMILK OR INFANT FORMULA.
2. BREASTMILK IS AN ACCEPTABLE MILK SUBSTITUTE FOR CHILDREN OF ANY AGE WITHIN THE CONTEXT OF THE CACFP.
3. AS SITUATIONS CHANGE, SUCH AS A MEDICAL AUTHORITY CHANGING AN INFANT'S FORMULA, A NEW FORM MUST BE COMPLETED.
4. IF THE PARENT/GUARDIAN DECLINES THE FORMULA AND THE CENTER/PROVIDER PROVIDES AT LEAST ONE **REQUIRED** MEAL AND/OR SNACK COMPONENT, THE MEAL OR SNACK MAY BE CLAIMED FOR REIMBURSEMENT.
5. IF THE PARENT/GUARDIAN DECLINES INFANT MEALS/SNACKS, THEY MAY NOT BE CLAIMED FOR REIMBURSEMENT.

This institution is an equal opportunity provider.