



Food & Nutrition Solutions

Infants Birth- 12 months CACFP Feeding Policy

CENTER NAME: Beginnings & Beyond - Spring

CHILD'S NAME: _____ **Date of Birth:** _____

Our center is currently participating in the USDA *Child and Adult Care Food Program*. We receive USDA reimbursement for serving nutritious meals to infants according to program requirements.

- We are required to provide meals to all children in attendance & we will be providing formula for our infants.
- We have chosen _____ as our formula.
- You have the option to accept or decline the formula supplied by our center.
- Please mark your selection below.

Parents (or guardians) complete the following table(s) as appropriate:

Please mark your preference (choose all that apply)	Today's Date	
	Birth – 5 Mths	6 – 11 Mths
I will bring breast milk for my infant.		
I want the center to provide the infant formula.		
I will bring the infant formula for my infant.		

According to CACFP requirements, in order to claim meals for reimbursement, the center must provide infant cereal and other foods when your infant is developmentally ready to accept them.

Please mark your preference	Today's Date
	6-11 Mths
I want the center to provide the infant cereal and	
I will bring the infant cereal and/or other foods for my infant.	

Parent's Signature _____

Date of Signature _____

Meals will be provided to all children without charge. This center's CACFP is operated in accordance with the USDA's policies and does not permit discrimination on the basis of race, color, sex, disability, national origin, age, religion, or political belief. To file a complaint of discrimination: (1) THHSC, Civil Rights Dept., Austin, TX 78714 or (2) USDA, Office of Civil Rights, 1400 Independence Avenue, Washington, DC 20250-9410. (800) 795-3272 or (202) 720-6382 (TTY)



CACFP ENROLLMENT FORM

Please complete the following information: Center

Name: Beginnings & Beyond - Spring

Phone Number: (281) 350-4012

Child 1:

Name: _____ Date of Birth: _____ Enrollment Date: _____

Days in care: ☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday ☐Saturday ☐Sunday

Times in care: Start time _____ ☐AM ☐PM End time _____ ☐AM ☐PM

Meals Served to child while in care: ☐Breakfast ☐AM Snack ☐Lunch ☐PM Snack ☐Supper ☐EV Snack

Withdrawal Date (office use only): _____

Child 2:

Name: _____ Date of Birth: _____ Enrollment Date: _____

Days in care: ☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday ☐Saturday ☐Sunday

Times in care: Start time _____ ☐AM ☐PM End time _____ ☐AM ☐PM

Meals Served to child while in care: ☐Breakfast ☐AM Snack ☐Lunch ☐PM Snack ☐Supper ☐EV Snack

Withdrawal Date (office use only): _____

Child 3:

Name: _____ Date of Birth: _____ Enrollment Date: _____

Days in care: ☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday ☐Saturday ☐Sunday

Times in care: Start time _____ ☐AM ☐PM End time _____ ☐AM ☐PM

Meals Served to child while in care: ☐Breakfast ☐AM Snack ☐Lunch ☐PM Snack ☐Supper ☐EV Snack

Withdrawal Date (office use only): _____

Child 4:

Name: _____ Date of Birth: _____ Enrollment Date: _____

Days in care: ☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday ☐Saturday ☐Sunday

Times in care: Start time _____ ☐AM ☐PM End time _____ ☐AM ☐PM

Meals Served to child while in care: ☐Breakfast ☐AM Snack ☐Lunch ☐PM Snack ☐Supper ☐EV Snack

Withdrawal Date (office use only): _____

Part 5. Signature (Adult must sign) An adult household member must sign and date this form.

I certify that all information on this form is true and correct. I understand that the center 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: _____ Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Meals will be provided to all children without charge. This center's CACFP is operated in accordance with the USDA's policies and does not permit discrimination on the basis of race, color, sex, disability, national origin, age, religion, or political belief. 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.

Part 6. Participant's ethnic and racial identities (optional) Mark one of the following:

☐ Hispanic or Latino	☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ White
☐ Not Hispanic/ Latino	☐ Native Hawaiian / Other Pacific Islander



CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Name of Child Care Facility or Day Care Home Provider: Beginnings & Beyond - Spring

Part 1. All Household Members

Name of Enrolled Child(ren):

Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) OR A HOMELESS CHILD * IF ALL CHILDREN LISTED BELOW ARE FOSTER OR HOMELESS CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Part 2. Benefits: If any member of your household receives SNAP, TANF, or FDPIR benefits, provide the name and eligibility number for the person who receives benefits. If no one receives these benefits, skip to Part 3.

NAME: _____ ELIGIBILITY NUMBER: _____

Part 3. (Applies only to parents/guardians with children enrolled in a day care home or day care home provider households) If any member of your household receives benefits listed on the enclosed *List of Eligible Federal/State Funded Programs (H1660)*, provide the name of the program and eligibility number:

NAME: _____ ELIGIBILITY NUMBER: _____

Check here if no eligibility number ☐

ADDITIONALLY, PLEASE ATTACH OFFICIAL EVIDENCE OF ENROLLMENT IN THE LISTED PROGRAM. If you are not a day care home provider, do not have a child enrolled at a day care, and/or are not participating in a qualifying program, **skip to Part 4.**

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List only household members with income) (Example) Jane Smith	B. Gross income and how often it was received Note: Self-employed report income after expenses in box 1			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
	\$200/weekly	\$150/twice a month	\$100/monthly	\$200/bi-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 or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the next page.)

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: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

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



CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

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

Mark one ethnic identity:

- ☐ Hispanic or Latino
☐ Not Hispanic or Latino

Mark one or more racial identities:

- ☐ Asian
☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander

Part 7. Sharing Information With Other Programs: OPTIONAL

The above information may be disclosed for the purpose of enrolling children in the Children's Health Insurance Program (CHIP). Parents/guardians are not required to consent to such disclosure and electing not to allow disclosure will not adversely affect a child's eligibility.

☐ I do elect to allow my household information to be disclosed.

☐ I do not elect to allow my household information to be disclosed.

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

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ☐ Week, ☐ Every 2 Weeks, ☐ Twice A Month, ☐ Month, ☐ Year Household size: _____

Categorical Eligibility: _____ Date Withdrawn: _____ Eligibility: Free _____ Reduced _____ Denied _____ Tier I _____ Tier II _____

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date: _____

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 the participant for free or reduced-price meal benefits. You must include the last four digits of the Social Security Number of the adult household member who signs the application; however, 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), or other qualifying program eligibility 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:

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, 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, audiotope, 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 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.