CACFP PARTICIPANT ENROLLMENT FORM

Child Development Center Name_____

Dear Parent/Guardian,

Your child care facility participates in the U. S. Department of Agriculture (USDA) child and Adult Care Food Program (CACFP). The enrolled participant will receive nutritious meals and snacks at no cost to you. CACFP needs verification of enrollment for each participant in this facility. Please complete the parent/guardian section of this form, sign it and return it to the Center Director. Provide information for one participant per section. This form must be completed for each participant annually. Thank you for your assistance.

PLEASE PRINT

Participant (child) Name: _____ Date of Birth: _____

Sex (circle one): Male Female Date Participant enrolled in the facility: _____

Food Allergies (N/A or list specifics): _____

*If the participant cannot be served the CACFP Meal Pattern, a statement from the participant's Health Care Provider must be provided.

Circle days child will be at center:

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Circle meals child normally eats at center:

Breakfast AM Snack Lunch PM Snack Supper Late night Snack

Please list the normal times of arrival and departure (circle AM or PM):

Arrival time: _____ AM or PM Departure Time: _____ AM or PM

FOR SCHOOL AGERS ONLY – WHEN SCHOOL IS IN SESSION

Arrival Time: _____ AM or PM Depart for School: _____ AM or PM

Arrival Time from School: _____ AM or PM Final Departure for day: _____ AM or PM

Parent/Guardian Signature: _____ Date: _____

Center Representative Signature: _____ Date: _____

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 discriminating 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). Individuals who are hearing impaired or have speech disabilities may contact USDA thought the Federal Relay Service at (800) 877-8339, or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

Child and Adult Care Food Program
INCOME ELIGIBILITY APPLICATION

New Mexico Early Childhood Education & Care Department

Name of Facility / Center / Site / Home Provider (Last, First, Middle Initial):	Facility / Center / Site / Home Provider EPICS ID:	Phone Number
CARITAS FELICES CENTER		(505) 515 / 6902

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.

Instructions: Complete this form and return to the Facility / Center / Site / Home Provider

ENROLLED PARTICIPANT INFORMATION: (Check if applicable for Enrolled Participant)

Case #:

First:	Last:	DOB:	Child Care Centers:	Adult Daycare Centers:	
			☐ Foster Child? ☐ SNAP ☐ FDPIR	☐ SSI ☐	
			☐ Foster Child? ☐ SNAP ☐ FDPIR	☐ SSI ☐	
			☐ Foster Child? ☐ SNAP ☐ FDPIR	☐ SSI ☐	
			☐ Foster Child? ☐ SNAP ☐ FDPIR	☐ SSI ☐	
			☐ Foster Child? ☐ SNAP ☐ FDPIR	☐ SSI ☐	

If Enrolled Participant is a Foster Child: Please list the amount of the child's "personal use" monthly income (if no personal income, record "0"): _____

HOUSEHOLD INFORMATION:

List the first and last name of each person living in the household, related or not (such as grandparents, other relatives, or friends who live in the household). Include yourself and all children over the age of 13 living with you. (Please use additional forms if more lines are required).

First:	Last:	First:	Last:

Total Number in Household: _____

HOUSEHOLD INCOME: Please indicate source and amount of current income for all members of your household. Please follow the definition of income specified in the standards for determining free and reduced-price eligibility in your parent letter. If you receive more than one check from any of these sources, please indicate the total ***monthly*** amount received.

Wages / Salary: $ _____ Child Support: $ _____ Social Security: $ _____ Pension/Retirement: $ _____

Unemployment: $ _____ Other Income: $ _____ **Total Income:** $ _____ ☐ Monthly

PENALTIES FOR MISREPRESENTATION: I certify that all the above information is true and correct and that the food stamp or FDPIR number is correct or that all income is reported. I understand that this information is being given for the receipt of Federal funds; that institution officials may verify the information on the statement and the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

_____ _____ ☐ Check if no SS# _____

Signature of Adult Family Member | Last Four Digits of Social Security Number* | Date

Privacy Act Statement:

This explains how we will use the information you give us. The Richard B. Russell National School Lunch Act requires that, unless the participant's food stamp or FDPIR number is provided, you must include the social security number of the household member signing the statement or an indication that the household member signing the statement does not possess a social security number. Provision of a social security number is not mandatory, but if a social security number is not provided or an indication is not made that the adult household member signing the statement does not have one, the statement cannot be approved. The social security number may be used to identify the household member in carrying out efforts to verify the correctness of the information on the statement. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a food stamp or FDPIR office to determine current certification for receipt of SNAP (food stamp) or FDPIR benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to verify the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal action if incorrect information is reported.

FOR SPONSOR'S USE ONLY

☐ Child Day Care Center ☐ Adult Day Care Center ☐ Approved Free ☐ Approved Reduced ☐ Paid

☐ Home Provider Tier I Eligibility Verified by: ☐ Tax Return ☐ W-2 ☐ Pay Stubs ☐ Other Date Verified: _____

☐ Home Provider Child(ren) Tier I Eligibility Verified by: ☐ Household Income ☐ Categorically Eligible School Name / District: _____

☐ Home Provider or Child(ren) TIER I Ineligible

_____ CARITAS FELICES CENTER _____ _____

Signature of Facility / Center / Site Representative / Home Provider | Name of Facility / Center / Site Representative / Home Provider | Approving Date | Date Disenrolled

* Complete Social Security Number is not required for CACFP Participation, only the last four digits are required