



**CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)**  
**SPRINGBOK ACADEMY**

**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) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.		CHECK IF NO INCOME
	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Part 2. Benefits:** If any member of your household receives SNAP, TANF, or FDPIR, 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)** 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

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

A. Name (List <b>only</b> household members with income) <i>(Example)</i> <i>Jane Smith</i>	B. Gross income and how often it was received <b>Note:</b> 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

New Update Drop In 

Center: SPRINGBOK ACADEMY

Enrollment

Date of Current CACFP Enrollment:				Date of Withdrawal:						
Child First Name	Child Last Name	Date of Birth	Days In Care			Meals Attending				
			MON	<input type="checkbox"/>	TUE	<input type="checkbox"/>	BREAKFAST	<input type="checkbox"/>	AM SNACK	<input type="checkbox"/>
Parent/Guardian Name		Arrive	WED	<input type="checkbox"/>	THR	<input type="checkbox"/>	LUNCH	<input type="checkbox"/>	PM SNACK	<input type="checkbox"/>
		AM <input type="checkbox"/> PM <input type="checkbox"/>	FRI	<input type="checkbox"/>			SUPPER	<input type="checkbox"/>	EV SNACK	<input type="checkbox"/>
Address		Depart	SAT	<input type="checkbox"/>	SUN	<input type="checkbox"/>				
City, ST, Zip		AM <input type="checkbox"/> PM <input type="checkbox"/>								
Phone		Race	White	<input type="checkbox"/>	Black	<input type="checkbox"/>	Asian	<input type="checkbox"/>	Other	<input type="checkbox"/>
Work Phone		Native American Indian	<input type="checkbox"/>	Alaska Native	<input type="checkbox"/>	Hawaiian/Pacific Islander	<input type="checkbox"/>			
Email		Ethnicity	Hispanic	<input type="checkbox"/>	Non-Hispanic	<input type="checkbox"/>				

**THIS SECTION MUST BE COMPLETED FOR INFANTS UNDER 12 MONTHS OF AGE**

Under the regulations of the USDA CACFP, this center is required to offer an iron-fortified formula of the center's choice.

This center offers this iron-fortified formula:

You may accept or decline the offered formula. Please select your preferences below:

<input type="checkbox"/> I accept the formula offered by this center.	<input type="checkbox"/> I decline the formula offered by this center and will bring expressed breast milk.	I decline the formula offered by this center and will bring this formula:  This formula is: <input type="checkbox"/> Iron-fortified <input type="checkbox"/> Low-iron <input type="checkbox"/> Iron free (If this formula is low-iron or iron free, I understand a medical statement must be provided to the center.)
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Under the regulations of the USDA CACFP, this center is required to offer solid foods such as iron-fortified infant cereal, vegetables, fruits, meat/meat alternates and crackers when an infant is developmentally ready to accept these components as recommended by the American Academy of Pediatrics and as specified in the Infant Meal Pattern. Please select your preferences below:

<input type="checkbox"/> I accept the solid foods offered by this center	<input type="checkbox"/> I decline the solid foods offered by this center and will bring the solid foods for my infant
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This center is required to update the feeding preferences of the infant as the situation changes as well as within one month of the infant changing age groups. Changes may include a change in the formula or foods. Please update any changes below (example: change formula to IF Similac; begin feeding IF infant cereal):

New Instructions:	Today's Date:	<input type="checkbox"/> My infant is: 0-5 mos	<input type="checkbox"/> My infant is: 6-11 mos
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Dear parent, because your day care provider cares about good nutrition, they have chosen the benefits of the Child and Adult Care Food Program (CACFP). This program is sponsored by **NUTRISERVICE INC**

Under the regulations of the CACFP, your provider may not charge you separate fees for meals, nor may you be asked to provide food for your child for those meals claimed under the program. 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 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. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: <https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint>, 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; fax: 202-690-7442; or email: [program.intake@usda.gov](mailto:program.intake@usda.gov). This institution is an equal opportunity provider and employer.

Signature of Parent/Guardian	Date of Signature
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