



Dear Small Wonders Academy Families,

Small Wonders Academy participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren).

The Federal CACFP regulations require all parents and guardians to complete a CACFP semi-annual Eligibility Form. This form must be completed upon enrollment and semi-annually thereafter. This information is strictly confidential and will help ensure all children will receive appropriate meals during their care.

We are asking for your cooperation in completing the:

1. Eligibility Form
2. If you have an infant in care here at Small Wonders Academy we will also need you to complete the Infant Enrollment form in addition to the above form.

Please remember the following:

1. The information you provide is strictly confidential. Only our CACFP coordinator will view your Enrollment and Eligibility forms.
2. As long as you fill out the forms we will be able to continue to provide your child with FREE meals regardless of what your income level is. Please fill the forms out to the best of your knowledge. No documentation is required.
3. If you have any questions at all please see the office. Your prompt attention to this matter is greatly appreciated.

Thank you!

Small Wonders Academy

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 meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. 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) case number for the participant or other (FDPIR) 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: 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 through 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 Child Care Center Meal Benefit Income Eligibility Form

| | | | | |
|---|--|--|------------------------------------|--|
| 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"/> |
| Part 2. Benefits: If any member of your household received [State SNAP], [FDPIR], or [State TANF cash assistance], provide the name and case number for the person who receives benefits. If no one receives these benefits, skip to part 3. NAME: _____ CASE NUMBER: _____ - _____ | | | | |
| Part 3. If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call [Your center director, Homeless Liaison, Migrant Coordinator at Phone #] Homeless <input type="checkbox"/> Migrant <input type="checkbox"/> Runaway <input type="checkbox"/> | | | | |
| Part 4. Total Household Gross Income—You must tell us how much and how often | | | | |
| A. Name (List only household members with income) <i>(Example)</i> <i>Jane Smith</i> | | B. Gross income and how often it was received | | |
| | | 1. Earnings from work before deductions | 2. Welfare, child support, alimony | 3. Pensions, retirement, Social Security, SSI, VA benefits |
| | | \$200/weekly _____ | \$150/twice a month _____ | \$100/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 back of this page.) <i>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.</i> | | | | |
| Sign Here: _____ | | Print Name: _____ | | |
| Date: _____ | | | | |
| Address: _____ | | Phone Number: _____ | | |
| City: _____ | | State: _____ | | Zip Code: _____ |
| Last four digits of Social Security Number: * * * - * * - _____ | | <input type="checkbox"/> I do not have a Social Security Number | | |
| Part 6. Participant's ethnic and racial identities (optional) | | | | |
| Mark one ethnic identity: | | Mark one or more racial identities: | | |
| <input type="checkbox"/> Hispanic or Latino | | <input type="checkbox"/> Asian | | |
| <input type="checkbox"/> Not Hispanic or Latino | | <input type="checkbox"/> White | | |
| | | <input type="checkbox"/> Black or African American | | |
| | | <input type="checkbox"/> American Indian or Alaska Native | | |
| | | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | | |

Do not fill this side out - 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: _____ Eligibility: Free _____ Reduced _____ Denied (Paid) _____ Date Withdrawn: _____

Reason for Denied: _____

Temporary: Free _____ Reduced _____ Time Period: _____ (expires after _____ days)

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

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

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

| Household size | Yearly |
|-------------------------|----------|
| 1 | \$21,775 |
| 2 | \$29,471 |
| 3 | \$37,167 |
| 4 | \$44,863 |
| 5 | \$52,559 |
| 6 | \$60,255 |
| 7 | \$67,951 |
| 8 | \$75,647 |
| Each additional person: | +\$7,696 |

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