



**Virginia Child and Adult Care Food Program (CACFP)
(Child) Annual Enrollment Form (AEF)**

CENTER/PROVIDER COMPLETE THIS SECTION

Unique Little Hands

Center/Provider Name

Street Address

City

State

Zip Code

This institution participates in the Child and Adult Care Food Program (CACFP) and receives Federal reimbursement to provide nutritious meals for children. Federal CACFP regulations require all parents/guardians to complete and sign a separate Annual Enrollment Form for each 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 6 below.**

This form is required for:

Child Care Centers, Family Day Care Homes

This form is NOT required for:

Outside School Hours Care Centers, Emergency Shelters

| 1 | FULL NAME OF ENROLLED CHILD (Include Birth Date/Age) | 2 | DAYS OF WEEK IN ATTENDANCE | 3 | | | 4 | MEALS RECEIVED | |
|---|---------------------------------------------------------|---|------------------------------------|---------------------------------------------------|----------|-------------------------------------------------|------------------------------------|----------------|-----------------------------------|
| | | | | TIMES CHILD NORMALLY ATTENDS CARE DURING THE WEEK | | | | | |
| | Child's First Name | | <input type="checkbox"/> Monday | TIME IN | TIME OUT | SPORADIC SCHEDULE (not set schedule of days) | <input type="checkbox"/> Breakfast | | |
| | Child's Last Name | | <input type="checkbox"/> Tuesday | | | | <input type="checkbox"/> AM Snack | | |
| | Date of Birth (mm/dd/yyyy) | | <input type="checkbox"/> Wednesday | NOTES: | | | <input type="checkbox"/> Lunch | | |
| | Age | | <input type="checkbox"/> Thursday | | | | | | <input type="checkbox"/> PM Snack |
| | | | <input type="checkbox"/> Friday | | | | | | <input type="checkbox"/> Supper |
| | | | <input type="checkbox"/> Saturday | | | | | | <input type="checkbox"/> EV Snack |
| | | | <input type="checkbox"/> Sunday | | | | | | |

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 Annual 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 HOME / 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, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, 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.

6 Ethnic and Racial Identification: *Parent/Guardian to complete. Please select ONE Ethnicity; Please select ONE OR MORE Races*

ETHNIC IDENTIFICATION

- Hispanic, Latino or Spanish Origin:** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- Not Hispanic, Latino or Spanish origin**
- I decline to answer.**

RACIAL IDENTIFICATION

- | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> American Indian or Alaskan Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains culture identification through tribal affiliation or community attachment (includes Aleuts and Eskimos). | <input type="checkbox"/> Black, African American, or Haitian: A person having origins in any of the black racial groups of Africa. |
| <input type="checkbox"/> Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. | <input type="checkbox"/> White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. |
| <input type="checkbox"/> Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. | <input type="checkbox"/> I decline to answer. |

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

Center Name Unique Little Hands

| 1 All Household Members | | | | 2 | 3 |
|------------------------------------------------------|--------------------------|--------------------------|--------------------------------------------|------------------------------------------------------------------------------------------------------|-----------------------------|
| NAMES OF ALL HOUSEHOLD MEMBERS [Adults and Children] | | | | FOSTER CHILD | SNAP, TANF or FDIPIR CASE # |
| First, Middle Initial, Last | Check if NO income | Ages of children in care | Skip to Part 6 if all are foster children. | Skip to Part 6 if you list a SNAP, TANF or FDIPIR case number. SNAP and TANF MUST BE NINE (9) DIGITS | |
| 1. | <input type="checkbox"/> | | <input type="checkbox"/> | | |
| 2. | <input type="checkbox"/> | | <input type="checkbox"/> | | |
| 3. | <input type="checkbox"/> | | <input type="checkbox"/> | | |
| 4. | <input type="checkbox"/> | | <input type="checkbox"/> | | |
| 5. | <input type="checkbox"/> | | <input type="checkbox"/> | | |
| 6. | <input type="checkbox"/> | | <input type="checkbox"/> | | |

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 or 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: _____

| | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> FREE based on: <input type="checkbox"/> foster child <input type="checkbox"/> migrant <input type="checkbox"/> SNAP, TANF, FDIPIR <input type="checkbox"/> homeless <input type="checkbox"/> runaway <input type="checkbox"/> household income | <input type="checkbox"/> REDUCED based on: <input type="checkbox"/> household income | <input type="checkbox"/> DENIED Reason: <input type="checkbox"/> income too high <input type="checkbox"/> incomplete application <input type="checkbox"/> non-qualifying SNAP/TANF |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

SECTION B Signature of Determining Official: _____ Date: _____

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 (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.
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NOTES:

Information on this form must be kept confidential.

Child Care Representative Use Only

| | |
|-----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Effective Date of This Enrollment Form: | <i>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.</i> |
| (mm/dd/yyyy) | |
| Effective Withdrawal Date of This Enrollment Form: | |
| (mm/dd/yyyy) | |
| Printed Name of Center Representative | <i>This form is effective for 12 months from the date of parent signature.</i> |
| Signature of Center Representative | |

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