

# Food Program Enrollment Form

Dear Parents:

**Little Explorers Academy** currently participates in the United State Department of Agriculture (USDA)'s Child Care Food Program. This program enables our school to provide nutritious meals and snacks to your children at no cost to you. We support this program to further the cause of the USDA to promote healthy living among our youth and provide them with access to nutritious meals.

In order for the school to continue to participate in the program, the attached forms must be completed by the parents. Please review and answer all questions accordingly, complete one enrollment form per child and one income eligibility form per family and return the form to the Center Director as soon as possible.

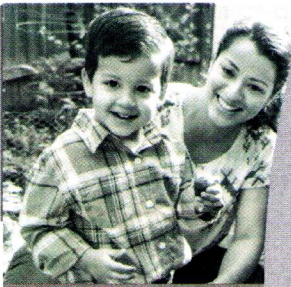
We look forward to your cooperation for this program as it will enable us to continue to provide the excellent care, service, and nutritious meals to your children.

Thank you for your cooperation.

The following income eligibility guidelines are used in determining the eligibility of a participant's household. These guidelines are based on 130% (free) and 185% (reduced) of the federal poverty guidelines and are effective July 1, 2021 – June 30, 2022

Household Size	Total Income									
	Annual		Monthly		Twice Monthly		Bi-Weekly		Weekly	
No. of Household Members	Free	Reduced	Free	Reduced	Free	Reduced	Free	Reduced	Free	Reduced
1	\$16,744	\$23,828	\$1,396	\$1,986	\$698	\$993	\$644	\$917	\$322	\$459
2	\$22,646	\$32,227	\$1,888	\$2,686	\$944	\$1,343	\$871	\$1,240	\$436	\$620
3	\$28,548	\$40,626	\$2,379	\$3,386	\$1,190	\$1,693	\$1,098	\$1,563	\$549	\$782
4	\$34,450	\$49,025	\$2,871	\$4,086	\$1,436	\$2,043	\$1,325	\$1,886	\$663	\$943
5	\$40,352	\$57,424	\$3,363	\$4,786	\$1,682	\$2,393	\$1,552	\$2,209	\$776	\$1,105
6	\$46,254	\$65,823	\$3,855	\$5,486	\$1,928	\$2,743	\$1,779	\$2,532	\$890	\$1,266
7	\$52,156	\$74,222	\$4,347	\$6,186	\$2,174	\$3,093	\$2,006	\$2,855	\$1,003	\$1,428
8	\$58,058	\$82,621	\$4,839	\$6,886	\$2,420	\$3,443	\$2,233	\$3,178	\$1,117	\$1,589
For each additional family member, add	+\$5,902	+\$8,399	+\$492	+\$700	+\$246	+\$350	+\$227	+\$324	+\$114	+\$162

**Note: We realize that this information is confidential and sensitive. We assure you that all completed forms are kept 100% confidential and the information will ONLY be used for the food program. It will not be disclosed to anyone else for any reason.**



# Building for the Future

This child care receives Federal cash assistance to serve healthy meals to your children. Good nutrition today means a stronger tomorrow!

Meals served here must meet nutrition requirements established by USDA's Child and Adult Care Food Program

## Questions? Concerns?

Call USDA at  
1-866-873-2263

Food and Nutrition at  
1-800-TELL-TDA  
(835-5832)

OR

## Your child care at : Little Explorers Academy

Contact Information: DeAna Kindt, Director

Address: 19433 T C Jester Blvd. Bldg. C

Phone Number: 281-547-8989

Email Address: LittleExplorersKids@gmail.com

### Other Necessary Information

Fraud Hotline: 1-866-5-FRAUD or 1-866-537-2834  
P.O. Box 12847 Austin TX 78711  
[www.SquareMeals.org](http://www.SquareMeals.org)  
USDA is an equal opportunity provider and employer.



TEXAS DEPARTMENT OF AGRICULTURE  
COMMISSIONER SID MILLER



# Join Texas WIC

## We're here for you

“Thanks to WIC,  
I now have the tools  
I need to make  
sure my family  
stays on the path to  
a healthy lifestyle.”

—Roxie, WIC Client

### As a WIC Client, you'll get:

- Delicious food
- One-on-one counseling with nutritionists
- Easy recipes
- Nutrition classes
- Breastfeeding support
- Health and immunization screenings
- Cooking demonstrations
- Personalized support
- Children's activities

### Are you eligible?

Eight million women, infants, and children get WIC benefits. WIC is for pregnant women, new parents, infants, and children under five. If you are on Medicaid, TANF, or SNAP you already qualify.

### Texas WIC Income Guidelines

Number of people in the home*	Monthly Income	Annual Income
2	\$2,686	\$32,227
3	\$3,386	\$40,626
4	\$4,086	\$49,025
5	\$4,786	\$57,424
6	\$5,486	\$65,823

Effective May 1, 2021

\* A pregnant woman's household is increased by the number of infants she is expecting. If you have any income questions, call 1-800-942-3678.



**Start now. Call 1-800-942-3678 or visit [TexasWIC.org](https://www.texaswic.org)**



This institution is an equal opportunity provider.

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## **Child and Adult Care Food Program (CACFP)**

I have received the following CACFP Documents:

- CACFP Letter to Households
- Enrollment Form
- WIC Guidelines
- Building for the Future Flyer

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**Child's Name**

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**Child's Name**

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**Child's Name**

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**Child's Name**

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**Parent Name**

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**Parent Signature**

**NEW**  **UPDATE**  **DROP IN**

Institution Name: Healthy Plate Solutions Agreement Number: 05001

Facility/Provider Name: \_\_\_\_\_

**Child and Adult Care Food Program (CACFP)**

**Participant Enrollment Form**

Your day 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 fill out the parent/guardian section of this form, sign it and return it to the above facility/provider. Provide information for one participant per section. **(In order for the institution to receive reimbursement for meals served/claimed, this form must be completed for each enrolled participant annually.)**

Parent/Guardian Please Complete:

**Participant's (Child) Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Sex:**  Male  Female **Date participant enrolled in the facility:** \_\_\_\_\_

**Food Allergies:**  Yes  No **If "yes" specify:** \_\_\_\_\_

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

**Check Days of Normal Care at facility:**  Sunday  Monday  Tuesday  Wednesday  Thursday  Friday  Saturday

**Check meals normally eaten at facility:**  Breakfast  AM Snack  Lunch  PM Snack  Supper  Evening Snack

**Please list the normal times of arrival and departure (check am or pm):** **Arrive:** \_\_\_\_\_  am  pm **Depart:** \_\_\_\_\_  am  pm

**RACE OF PARTICIPANT:** You are NOT required to answer this question.

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

**ETHNIC IDENTITY:** You are NOT required to answer this question.

- Hispanic or Latino  Not Hispanic or Latino

**If participant is an infant (0-11 months), please complete this box. Check all applicable choice(s) below:**

This institution/facility offers \_\_\_\_\_ formula for infants through CACFP. It is your choice whether or not to use this formula based on your infant's needs. Baby foods provided by the institution/facility must be in compliance with the infant meal pattern as required by 7CFR 226.20.

Please mark your preference (choose all that apply)	Today's Date	Today's Date
	Birth - 5 months	6 - 11 months
I will bring expressed breastmilk for my infant.		
I want the provider to provide the infant formula for my infant.		
I will bring the infant formula for my infant. Please list the kind of infant formula you will bring.		

According to CACFP requirements, in order to claim meals for reimbursement, the provider 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 months
I want the provider to provide the infant cereal and other foods for my infant.	
I will bring the infant cereal and/or other foods for my infant.	
My child is NOT developmentally ready for solid foods. I will inform the provider when and designate the solid food(s) to be introduced to my infant at that time.	

*Note to parents who are getting formula through the WIC Program: Your baby is eligible to get formula from this child care institution/facility as well as from the WIC Program. It is your decision which formula you want your baby to use when she/he is at child care. If you find you are getting more formula than your baby needs, you may wish to talk with your WIC nutritionist or your child care provider.*

I hereby certify the information given on this sheet is true and correct to the best of my knowledge. I also certify that I was given CACFP Meal Benefits Income Eligibility Form Letter to Household, the WIC information, Building for the Future Flyers, Civil Rights Appeals Procedures.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Home Telephone Number:** \_\_\_\_\_ **Date Dropped:** \_\_\_\_\_

**Work Telephone Number:** \_\_\_\_\_ **Emergency Telephone Number:** \_\_\_\_\_

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 and Compliance, 1400 Independence Avenue SW, Washington, DC 20250-9401 or call (866) 632-9992, (202) 260-1026 or (202) 401-0216 (TDD). This institution is an equal opportunity provider and employer.



## CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

### 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"/>

**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 case number

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

A. Name (List only household members with income)	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
<i>(Example)</i> Jane Smith	\$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 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) eligibility 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:

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.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;  
This institution is an equal opportunity provider.
- (2) fax: (202) 690-7442; or (3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov).