



CACFP Food Program Enrollment Form

Center Name:

Phone Number:


Child 1	1 – Child's Name:
	2 – Date of Birth:
	3 – Enrollment Date:
	4 – Days in Care: <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday
	5 – Start Time in Care: <input type="checkbox"/> AM <input type="checkbox"/> PM
	6 – End Time in Care: <input type="checkbox"/> AM <input type="checkbox"/> PM
	7 – Meals Served to Child While in Care: <input type="checkbox"/> Breakfast <input type="checkbox"/> AM Snack <input type="checkbox"/> Lunch <input type="checkbox"/> PM Snack <input type="checkbox"/> Supper <input type="checkbox"/> EV Snack
(For Office Use Only) Withdrawal Date:	

Child 2	1 – Child's Name:
	2 – Date of Birth:
	3 – Enrollment Date:
	4 – Days in Care: <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday
	5 – Start Time in Care: <input type="checkbox"/> AM <input type="checkbox"/> PM
	6 – End Time in Care: <input type="checkbox"/> AM <input type="checkbox"/> PM
	7 – Meals Served to Child While in Care: <input type="checkbox"/> Breakfast <input type="checkbox"/> AM Snack <input type="checkbox"/> Lunch <input type="checkbox"/> PM Snack <input type="checkbox"/> Supper <input type="checkbox"/> EV Snack
(For Office Use Only) Withdrawal Date:	

Child 3	1 – Child's Name:
	2 – Date of Birth:
	3 – Enrollment Date:
	4 – Days in Care: <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday
	5 – Start Time in Care: <input type="checkbox"/> AM <input type="checkbox"/> PM
	6 – End Time in Care: <input type="checkbox"/> AM <input type="checkbox"/> PM
	7 – Meals Served to Child While in Care: <input type="checkbox"/> Breakfast <input type="checkbox"/> AM Snack <input type="checkbox"/> Lunch <input type="checkbox"/> PM Snack <input type="checkbox"/> Supper <input type="checkbox"/> EV Snack
(For Office Use Only) Withdrawal Date:	

Child 4	1 – Child's Name:
	2 – Date of Birth:
	3 – Enrollment Date:
	4 – Days in Care: <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday
	5 – Start Time in Care: <input type="checkbox"/> AM <input type="checkbox"/> PM
	6 – End Time in Care: <input type="checkbox"/> AM <input type="checkbox"/> PM
	7 – Meals Served to Child While in Care: <input type="checkbox"/> Breakfast <input type="checkbox"/> AM Snack <input type="checkbox"/> Lunch <input type="checkbox"/> PM Snack <input type="checkbox"/> Supper <input type="checkbox"/> EV Snack
(For Office Use Only) Withdrawal Date:	

By signing this form, I acknowledge that I have received the enrollment and income form for the CACFP, as well all supplemental information, including Form 1625A, Letter to Households, Building for the Future and WIC flyers.

 <p>Did you complete all 7 steps for each child?</p>	8 – Signature – Parent or Guardian	9 – Date of Signature
	Parent/Guardian Email Address	Parent/Guardian Phone No.

This center's CACFP is operated in accordance with the USDA's policies and does not permit discrimination on the basis of color, sex, disability, national origin, age, religion, or political beliefs. Complaints regarding discrimination should be forwarded to the following parties: (1) TDA, Civil Rights Dept, Austin, TX 78714 or (2) USDA, Office of Civil Rights, Washington, DC 20250- 9410.



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"/>

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 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
(Example) 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:	Mark one or more racial identities:	
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian or Alaska Native
<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
	<input type="checkbox"/> Black or African American	

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, 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.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or

(2) fax: (833) 256-1665 or (202) 690-7442; or (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

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	\$ 3,041	\$ 36,482
3	\$ 3,833	\$ 45,991
4	\$ 4,625	\$ 55,500
5	\$ 5,418	\$ 65,009
6	\$ 6,210	\$ 74,518

Effective April 1, 2023

* 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.



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

OR

Food and Nutrition Division at
1-800-TELL-TDA
(835-5332)

Your child care at Coastal Child Nutrition Services

Contact Information: CACFP Sponsor

Address: 1607 S. Chestnut St. Suite M, Lufkin, TX 75901

Phone Number: (888) 837-3804

Email Address: ccns@mycacfp.com

Other Necessary Information: www.mycacfp.com



TEXAS DEPARTMENT OF AGRICULTURE
COMMISSIONER SID MILLER

Fraud Helpline: 1-866-5-FRAUD-4 or 1-866-537-2834 | P.O. Box 12847 | Austin, TX 78711
Toll Free: (877) TELL-MEAL | For the hearing impaired: (600) 735-2869 (TTY)

This product was funded by USDA.

This institution is an equal opportunity provider.

Food and Nutrition Division
Child and Adult Care Food Program



Updated 11/17/2021
www.SquaresMeals.org

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a childcare center. This center offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in childcare. Please help us comply with the requirements of the CACFP by completing the attached Meal Benefit Income Eligibility Form. In addition, by filling out this form, we will be able to determine if your child(ren) qualifies for free or reduced-price meals.

- Do I need to fill out a Meal Benefit Form for each of my children in day care?** You may complete and submit one CACFP Meal Benefit Income Eligibility Form for all children enrolled in childcare in your household only if the children in child care are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. **Return the completed form to our day care center.**
- Who can get free meals without providing income information?** Children in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) can get free meals. Foster children (reference question #8 for more information on foster children) and children enrolled in a Head Start Program (HSP), Early Head Start Program (EHSP), or Even Start Program (ESP) and have not entered kindergarten) are also eligible for free meals. Households with children enrolled in a HSP, EHSP or ESP can provide a certification letter from the program of the child's enrollment and do not need to complete the CACFP Meal Benefit Income Eligibility Form.
- Who can get reduced price meals?** Your children can get low-cost meals if your household income is within the reduced-price limits on the Income Chart, sent with this application. Children in households participating in WIC may be eligible for reduced price meals.
- May I fill out a form if someone in my household is not a U.S. citizen?** Yes. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center.
- Who should I include as members of my household?** You must include everyone in your household (such as grandparents, other relatives, or friends who live with you) who shares income and expenses. You must include yourself and all the children who live with you. You also may include foster children who live with you.
- How do I report income information and changes in employment status?** The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income Chart, the center will receive a higher level of reimbursement. Once properly approved for free or reduced-price benefits, whether through income or by providing a current SNAP, TANF, FDPIR case number, you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the eligibility standards.
- What if my income is not always the same?** List the amount that you normally get. For example, if you normally get \$1000 each month, but you missed some work last month and only got \$900, put down that you get \$1000 per month. If you normally get overtime, include it, but not if you only get it sometimes.
- What if I have foster children?** Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the Meal Benefit Form but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children can provide the Texas Department of Family and Protective Services Form 2085FC, Placement Authorization Foster Care/Residential Care, to their child's caregiver and do not need to complete the CACFP Meal Benefit Income Eligibility Form.
- We are in the military, do we include our housing and supplemental allowances as income?** If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.
- (Pricing program only) Will the information I give be verified?** Maybe. We may ask you to send written proof to verify the information you submitted on the form. **What if I disagree with the decision about the information I complete on this form?** You can talk to our center's director, either in person or by telephone. You may ask for a hearing by calling or writing to our day care facility.

In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex, age or disability.

If you have other questions or need help, call our facility at the number listed on your enrollment form.

July 2011

CACFP Meal Benefit Income Eligibility Form
Letter to Households (Child Care Centers)

Texas Department of Agriculture		Form H1625-A February 2023			
Income Eligibility Guidelines for Determining Free or Reduced-Price Benefits July 1, 2023 – June 30, 2024			Ingresos máximos para determinar la elegibilidad para beneficios gratuitos o a precio reducido 1 de julio de 2023 - 30 de junio de 2024		
<p>Children from households whose incomes are at or below the levels shown below, or who receive Temporary Assistance for Needy Families (TANF) or Supplemental Nutrition Assistance Program (SNAP) benefits, are eligible for free or reduced-price meals.</p> <p>Adult Day Care participants whose household incomes are at or below the levels shown below, or who receive Medicaid, Supplemental Security Income (SSI), or SNAP benefits, are eligible for free or reduced-price meals.</p>			<p>Los niños de hogares con ingresos iguales o menores a los niveles que se muestran a continuación, o que reciben Asistencia Temporal para Familias Necesitadas (TANF), ayuda del Programa Suplementario de Asistencia Nutricional (SNAP), o del Programa de Distribución de Alimentos en Reservas Indígenas (FDPIR) califican para recibir comidas gratuitas o a precio reducido.</p> <p>Las personas que participan en programas de Cuidado Diario para Adultos cuyos ingresos familiares son iguales o por debajo de los niveles que se muestran a continuación, o que reciben Medicaid, Seguridad de Ingreso Suplementario (SSI), TANF, o beneficios de SNAP o FDPIR califican para recibir comidas gratuitas o a precio reducido.</p>		
FAMILY SIZE	ANNUAL	MONTHLY	TWICE MONTHLY	BI-WEEKLY	WEEKLY
1	\$26,973	\$2,248	\$1,124	\$1,038	\$519
2	\$36,482	\$3,041	\$1,521	\$1,404	\$702
3	\$45,991	\$3,833	\$1,917	\$1,769	\$885
4	\$55,500	\$4,625	\$2,313	\$2,135	\$1,068
5	\$65,009	\$5,418	\$2,709	\$2,501	\$1,251
6	\$74,518	\$6,210	\$3,105	\$2,867	\$1,434
7	\$84,027	\$7,003	\$3,502	\$3,232	\$1,616
8	\$93,536	\$7,795	\$3,898	\$3,598	\$1,799
For each additional family member add:	\$9,509	\$793	\$397	\$366	\$183