

Your child is enrolled in a center that participates in the Child and Adult Care Food Program (CACFP). By participating in this Program, the center follows federal meal pattern requirements and receives reimbursement to assist with food costs. The CACFP requires parents to provide specific enrollment information on an annual basis. This form will be placed in center files and treated as confidential information. Complete one form for all of your children who are enrolled at the center.

Iowa Child and Adult Care Food Program Child Care Enrollment Form

Last Name, First Name	Birthdate	Times of Care		Regular Days of Care							Meals Served During Care					Ethnicity/Race*				
		Arrival	Departure	M	T	W	Th	F	S	S	B	AM Sn	Lu	PM Sn	D	E Sn	Ethnicity	Race		

*Ethnicity (Select one and enter in the chart above): H=Hispanic or Latino or N=Not Hispanic or Latino
 *Race (Select one or more and enter in the chart above): W=White, B=Black or African American, I=American Indian or Alaska Native, A=Asian, and P=Native Hawaiian or Other Pacific Islander This information is requested by the Federal Government in order to monitor compliance with Civil Rights law. You are not required to furnish this information, but are encouraged to do so. The law requires that organizations may not discriminate on the basis of this information nor on whether you choose to furnish it.

Infants only (0 to 12 months): I am not enrolling an infant (skip this section)

As a participant in a USDA Child Nutrition Program, our center offers meals to children of all ages; you are not required to provide infant food or formula. Infant feeding is based on Academy of Pediatrics nutrition guidelines. Infant foods served are appropriate for the age and developmental readiness of your infant. Mark (X) to indicate your choice(s) below:

- I will provide breastmilk for my infant. Yes No **If infant is still hungry and no breastmilk is available, list what to feed** _____
- I would like to breastfeed on site, if this option is available¹. Yes No If yes, time(s) _____
- I will provide formula for my infant. Name of formula (must be iron-fortified and manufactured in the USA): _____
- I accept the center's formula for my infant. Name of iron-fortified formula: _____
- I will submit a Diet Modification Request Form for non-reimbursable formula. Name of formula: _____
- I accept the center's solid foods (appropriately textured) to be served to my infant as s/he is ready for them, and after I have discussed it with the caregiver.
- I will provide solid foods for my infant². The center may supplement with additional solid foods when my infant needs them: Yes No

Parent Signature _____ Date: _____

Parent Signature _____ Date: _____ (Make any needed changes above, sign and date)

Parent Signature _____ Date: _____ (Make any needed changes above, sign and date)

¹Ask your center if you can breastfeed on-site.

²The parent may provide no more than one required meal component in order for the center to claim reimbursement for the meal. DHS licensed centers must follow CACFP infant meal pattern requirements regardless of who supplies the food. Your center can provide a copy of the CACFP infant meal pattern and a list of reimbursable foods upon request.

This institution is an equal opportunity provider.

Iowa Eligibility Application
 Complete one application per household. Fiscal Year 2023-2024
 Translated applications are available at: <http://www.fns.usda.gov/school-meals/translated-applications>

Part 1. Check if any child is Homeless, Migrant, or a Runaway and call your child's school. Run away Migrant Homeless

Part 2. FIP or SNAP Eligible: Enter the FIP or SNAP Case Number for ANY household member as listed in the Notice of Decision (10 digits, include zeros). NOTE: Medicaid, Title XIX and EBT card numbers are not acceptable. Skip part 4.

Name of household member with Case Number _____ List Case Number - - - - -

Part 3. Children enrolled: REQUIRED OF ALL APPLICANTS.

List name(s) of all enrolled child(ren) in your household.			Ethnicity: H=Hispanic or Latino N=Not Hispanic or Latino		Race: A = Asian B = Black or African American I = American Indian or Alaska Native W=White		Completing ethnicity & race is voluntary		Name of School/Head Start/ Child Care Center/Home
Last Name	First Name	Middle Name or Initial	Check box for foster child	Date of Birth	Grade	OPTIONAL			
						ETHNICITY	RACE		
1.			<input type="checkbox"/>						
2.			<input type="checkbox"/>						
3.			<input type="checkbox"/>						
4.			<input type="checkbox"/>						
5.			<input type="checkbox"/>						

Part 4. Total Household Gross Income: DO NOT COMPLETE PART 4 IF YOU LISTED A FIP OR SNAP NUMBER IN PART 3.

List all Household Members (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report. For foster children, include only money available for child's personal use or child's own income.

First and Last Name	Age	Gross Earnings From work/ all other income: How Often? (Mark "X" in box)					Gross Public Assistance/ Child Support/ Alimony How Often? (Mark "X" in box)				Gross Pension/ Retirement How Often? (Mark "X" in box)			
		Weekly	Bi- Weekly	2x month	Monthly	Yearly	Weekly	Bi- Weekly	2x month	Monthly	Weekly	Bi- Weekly	2x Month	Monthly
1.		\$					\$				\$			
2.		\$					\$				\$			
3.		\$					\$				\$			
4.		\$					\$				\$			
5.		\$					\$				\$			

Last four digits of my Social Security Number: X XX - X X - _____ I do not have a Social Security Number.
 If Part 4 is completed, the adult signing the form must provide the last 4 digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. For further information refer to the Privacy Act Statement in the parent letter.

Part 5. Certification and Signature. REQUIRED OF ALL APPLICANTS.

I certify (promise) that all information on this application is true and that all income is reported if required. I understand that I will receive benefits from Federal funds based on the information I give. I understand that officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal/milk benefits, and I may be prosecuted. Email of Adult Completing Form _____

Signature of Adult Completing Form _____ Printed Name of Adult Completing Form _____ Date Signed _____

Address of Adult Completing Form _____ Town _____ ZIP Code _____ Work Phone _____ Home Phone _____ Cell Phone _____

Part 6. TO BE COMPLETED BY CENTER STAFF.

Income conversion factors for annual income: weekly X 52; two weeks X 26; twice a month X 24; monthly X 12
 Household Income: \$ _____ Weekly Every 2 Weeks Twice Monthly Monthly Annually Household Size _____

Application Approved:	<input type="checkbox"/> Income	<input type="checkbox"/> Foster Child (free)	<input type="checkbox"/> FIP/SNAP	CACFP HP ONLY: <input type="checkbox"/> Tier 1 Area (Provider's own children)
	<input type="checkbox"/> Head Start DOCUMENTATION REQUIRED		<input type="checkbox"/> Homeless/Migrant/Runaway (Schools only)	
Eligibility Determination:	<input type="checkbox"/> Free Meals	<input type="checkbox"/> Reduced Price Meals	<input type="checkbox"/> Free Milk	<input type="checkbox"/> Tier 1 Income (All children)
Application Denied:	<input type="checkbox"/> Incomplete	<input type="checkbox"/> Over income limits		<input type="checkbox"/> Tier 1 Child (Tier 2 mixed)

Center Determining Official Signature _____ Effective Date _____

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 submit all needed information, we cannot approve your child 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 last four digits of 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), Family Investment Program (FIP) or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child 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 your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

Self-Employment Income Worksheet: This worksheet will help you calculate the amount to report if you farm, are self employed, or have income from other sources.

Persons who are engaged in farming or who operate other types of private businesses may experience variations in cash flow or monthly income throughout the year. These persons may use their income tax records from the preceding calendar year as a basis for applying for meal benefits. The income to be reported is income derived from the business venture less operating costs incurred in the generation of that income. Deductions for personal expenses such as medical expenses and other non-business deductions are not allowed in reducing gross business income.

If you have additional income from other kinds of employment, this income must be treated as separate and apart from the income generated from your business venture. USDA **DOES NOT** recognize income the same way as IRS. USDA does not permit a loss from a business venture to off-set earnings from wages or salary. Though your business may have suffered a net operational loss, for purposes of this Application, it is not possible to have a negative income. The **least self-employed income possible is zero (no income)**. For example, if you operated a business at a net loss but held another job where you received wages, your income for purposes of applying for Tier 1 meals would be the income from your wages only. The loss from the business cannot be deducted from the amount of the income earned in the other job.

A prior year loss from farming or other private business operation cannot be used to reduce the current year net income for determining free and reduced-price eligibility. Wages paid to a spouse or other family or household member in the operation of a farm or private business must be shown as household income in Part 5 of this Application.

Income from private business operations is to be taken from your most recent U.S. Individual Income Tax Return – Form 1040 or 1040-SR including Schedule 1 (Additional Income and Adjustments to Income). Complete the identified lines from Form 1040 or Form 1040-SR and Schedule 1.

Capital gain or (loss): Form 1040 or 1040-SR, Line 7	\$ _____
Business income or (loss): Schedule 1 Part 1, Line 3	\$ _____
Other gains or (losses): Schedule 1 Part 1, Line 4	\$ _____
Rental real estate, royalties, partnerships, S corporations, trusts, etc.: Schedule 1 Part 1, Line 5	\$ _____
Farm income or (loss): Schedule 1 Part 1, Line 6	\$ _____
*Total =	\$ _____

*The least income possible is zero (a negative number cannot be reported).

*Enter amount in the "All other Income" column in Part 4 on the front of this Application.

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:

*MAIL: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

FAX: (833) 256-1665 or (202) 690-7442; or
EMAIL: program.intake@usda.gov

*Do not mail applications to this address, only complaints of discrimination.

Iowa Non-Discrimination Statement: "It is the policy of this CNP provider not to discriminate on the basis of race, creed, color, sex, sexual orientation, gender identity, national origin, disability, age, or religion in its programs, activities, or employment practices as required by the Iowa Code section 216.6, 216.7, and 216.9. If you have questions or grievances related to compliance with this policy by this CNP Provider, please contact the Iowa Civil Rights Commission, Grimes State Office building, 400 E. 14th St. Des Moines, IA 50319-1004; phone number 515- 281-4121, 800-457-4416; website: <https://icrc.iowa.gov/>."