

Food Program Enrollment Form for FP Assistance  
(02328)

Center Name: Fit For Kids Too CODE: F-157

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Admission date: \_\_\_\_\_ Withdrawal Date: \_\_\_\_\_

1. Circle the days that your child will normally attend the center:

Mon    Tue    Wed    Thu    Fri    Sat    Sun

2. Circle the meals normally served to your child in the center:

Breakfast    AM Snack    Lunch    PM Snack    Supper    Evening Snack

3. What hours will your child normally be in the center:

\_\_\_\_\_:\_\_\_\_\_ to \_\_\_\_\_:\_\_\_\_\_

4. Participant's ethnic and racial identities (optional)

Ethnicity (choose one ethnic identity):

- Hispanic or Latino  
 Not Hispanic or Latino

Race: (choose one or more racial identities):

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

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date of Signature

(\_\_\_\_\_) \_\_\_\_\_  
Day Time Phone Number

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# CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

## Part 1. All Household Members

CODE: F-157

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"/>
	<input type="checkbox"/>	<input type="checkbox"/>

**Part 2. Benefits:** If any member of your household receives SNAP, TANF, or FDPIR, 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. (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 case number: NAME: \_\_\_\_\_ CASE 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 <b>only</b> 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	4. All Other Income
	\$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