Child and Adult Care Food Program (CACFP) Enrollment Form (ADULT)

CENTER REPRESENTATIVE COMPLETE THIS SECTION

CENTER NAME:	
CENTER ADDRESS:	*STREET* _____ *CITY* _____ *STATE* *ZIP CODE*

An Enrollment Form must be completed when the participant enters the Program. Adult Day Care Centers are responsible for updating each participant's Individual Plan of Care annually and must keep the Enrollment Form on file as long as the participant remains in the Program. **The participant or legal guardian must complete and ensure accuracy of Sections 1 through 5 below**.

1	**FULL NAME and AGE of ENROLLED PARTICIPANT:**	_____
2	**DAYS OF WEEK IN ATTENDANCE:**	☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY

3 TIME PARTICIPANT NORMALLY ATTENDS CARE DURING THE WEEK:

TIME IN:	**TIME OUT:**	**SPORADIC SCHEDULE:** *(NO SET SCHEDULE OF DAYS/TIME)*
NOTES:		

4 MEALS RECEIVED:

☐ **BREAKFAST** ☐ **AM SNACK** ☐ **LUNCH** ☐ **PM SNACK** ☐ **SUPPER** ☐ **EVENING SNACK**

5 PARTICIPANT/LEGAL GUARDIAN CERTIFICATION *(NAME, SIGNATURE, ADDRESS, PHONE, DATE)*

By signing this form, I certify that I am the participant or legal guardian of the participant named in Section 1 of this Enrollment Form and that the information contained on this form is true and correct.

PARTICIPANT/LEGAL GUARDIAN PRINT NAME:		**SIGNATURE:**	
PARTICIPANT'S ADDRESS:	*STREET* _____ *CITY* _____ *STATE* *ZIP CODE*		
WORK/CELL PHONE: *(CIRCLE ONE)*		***DATE:*** *(MM/DD/YY)*	

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, 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 on-line 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.

OFFICIAL CENTER USE ONLY: CENTER REPRESENTATIVE TO COMPLETE THIS SECTION

EFFECTIVE DATE OF ENROLLMENT FORM: *(MM/DD/YYYY)*		**EFFECTIVE DATE OF WITHDRAWAL:** *(MM/DD/YYYY)*	

The effective date may be retroactive to the first day the enrollee participates in the CACFP as long as it occurs in the same month this form is received.

CENTER REPRESENTATIVE PRINT NAME:		**TITLE:**	
CENTER REPRESENTATIVE SIGNATURE:		**DATE:** *(MM/DD/YYYY)*	

VIRGINIA CACFP
Child and Adult Care Food Program

(ADULT) CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (IEF)

1 ALL HOUSEHOLD MEMBERS

NAME OF ENROLLED ADULT(S):

	FIRST NAME, MIDDLE INITIAL, LAST NAME	Check if **NO** income
1		
2		
3		

2 SNAP, SSI, Medicaid or FDPIR CASE NUMBER

Skip to part 4 if case number is listed. Case numbers must contain the following: **SNAP = NINE (9) DIGITS; SSI = NINE (9) DIGITS; MEDICAID = TWELVE (12) DIGITS**

3 TOTAL HOUSEHOLD GROSS INCOME *(Before Deductions)*

PLEASE INDICATE HOW MUCH AND HOW OFTEN.

GROSS INCOME AND HOW OFTEN RECEIVED: (i.e.: $100/month, $100/ twice a month, etc.)

NAMES OF HOUSEHOLD MEMBERS WITH INCOME:	Earnings From Work		Welfare, Child Support, Alimony		Pension, Retirement, Social Security		All Other Income (Worker's Comp, Unemployment, SSDI)	
	Amount	How Often	Amount	How Often	Amount	How Often	Amount	How Often
1								
2								
3								

4 PARTICIPANT RESIDENCY/LIVING ARRANGEMENTS

Each adult day care center shall maintain records that document qualified adult day care participants reside in their own home(S) (whether alone or with spouse(s), child(ren) or guardian(s)), or in Group Living Arrangements. *Group Living Arrangements* mean residential communities that may or may not be subsidized by Federal, State or local funds, but which are private residences housing an individual or group of individuals that are primarily responsible for their own care and that maintain a presence in the community and may receive on-site monitoring. (7 CFR 226.2 and 226.19)

I, _____(PRINT PARTICIPANT NAME) **reside in:**

_____**MY OWN HOME** (ALONE OR WITH SPOUSE, CHILD(DREN), GUARDIAN) _____**FAMILY MEMBER/GUARDIAN HOME** _____**RESIDENTIAL FACILITY**

IF RESIDENTIAL FACILITY, PLEASE IDENTIFY FACILITY TYPE: _____**ASSISTED LIVING** _____**NURSING HOME** _____ **GROUP HOME** _____ **OTHER FACILITY**

NAME OF FACILITY/HOME: _____ **ADDRESS OF FACILITY/HOME:** _____

5 SIGNATURE and SOCIAL SECURITY NUMBER *(Adult Participant or Guardian MUST Sign)*

IF PART 3 IS COMPLETED OR IF ZERO INCOME IS LISTED, THE ADULT SIGNING THE FORM MUST ALSO LIST THE LAST FOUR (4) DIGITS OF HIS/HER SOCIAL SECURITY NUMBER OR CHECK THE *I DO NOT HAVE A SOCIAL SECURITY NUMBER* BOX.

X X X – X X - _____
LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER

I DO NOT HAVE A SOCIAL SECURITY NUMBER

I CERTIFY THAT INFORMATION ON THIS FORM IS TRUE AND CORRECT. ALL INCOME IS REPORTED. I UNDERSTAND THAT THE CENTER WILL RECEIVE FEDERAL FUNDING BASED ON THE INFORMATION REPORTED ON THIS FORM. I UNDERSTAND THAT CACFP DETERMINING OFFICIALS MAY VERIFY THIS INFORMATION. I UNDERSTAND THAT IF I PURPOSELY PROVIDE FALSE INFORMATION, THE PARTICIPANT RECEIVING MEALS MAY LOSE THE MEAL BENEFIT AND PARTICIPANT/GUARDIAN MAY BE PROSECUTED IN ACCORDANCE WITH FEDERAL AND STATE LAWS AND REGULATIONS.

DATE (mm/dd/yyyy) ***PRINTED NAME OF PARTICIPANT OR GUARDIAN*** ***SIGNATURE OF PARTICIPANT OR GUARDIAN***

OFFICIAL CENTER USE ONLY: ELIGIBILITY DETERMINATION OFFICIAL 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**

TOTAL NUMBER IN HOUSEHOLD: _____ ***CIRCLE ONE:*** **FREE** **REDUCED** **PAID**

SECTION B

SIGNATURE OF DETERMINING OFFICIAL: _____ **DATE:** _____

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