Combined Enrollment And Eligibility Form For CACFP July 1, 2021 through June 30, 2022

This Center Participates In The Child and Adult Care Food Program: **Site Number 892**

Skyers Child Development Center

First Name Include Nicknames	Last Name	Date of Birth	Normal Drop Off And Pick Up Times		Indicate Child's Normal Days of Care	Indicate Normal Meals Child Receives Daily[1]
			Drop Off :	Pick Up :	M TU W TH F S SU	B AM LU PM SU EVE
			Drop Off :	Pick Up :	M TU W TH F S SU	B AM LU PM SU EVE
			Drop Off :	Pick Up :	M TU W TH F S SU	B AM LU PM SU EVE
			Drop Off :	Pick Up :	M TU W TH F S SU	B AM LU PM SU EVE

[1] B=Breakfast AM= Morning Snack LU= Lunch PM= Afternoon Snack SU=Supper EVE=Evening Snack

Check One Ethnicity Below:

Hispanic ☐

Non-Hispanic ☐

Check One Or More Race(s) Below:

☐ American Indian Including South or Central America/Alaskan Native

☐ Black/African American ☐ Asian ☐ White

☐ Native Hawaiian/Other Pacific Islander

* **Enter Confidential Eligibility Information In Boxes A, B, C, and/or D**

Everyone signs in Box E : ❤

Box A

Name any children on this form who are enrolled in Head Start:

1._____ **2.**_____ **3.**_____ **4.**_____

Box B

Name any children on this form who are Court Appointed Foster Children living with you or Homeless Children you are hosting (including children evacuated from Japan or Bahrain): See Box B On Back

1._____ **2.**_____ **3.**_____ **4.**_____

Box C

Enter a case number here if you have one:

SNAP (Food Stamps) #_____ **TANF #**_____ **FDPIR#**_____

Box D

IF you enter nothing in Boxes A, B, or C AND your before-tax household income falls below the guidelines on the back in Box D, enter names and income amounts below for all people in your household *other than the children on this form*. Include Yourself!:

Names of household members	Monthly wages	Monthly Social Security Check	Monthly child support or public assistance	Monthly retirement pensions check	Monthly Other Earnings
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$

ONLY IF you fill out Box D, enter last 4 digits of your Social Security # XXX-XX-☐☐☐☐ **Check if you don't have a SS #** ☐

❤ **Box E EVERYONE Signs HERE:**

Date:_____ **Parent/Guardian Signature:**_____ **Print Name:** _____

Street Address:_____ **City:**_____ **Zip:** _____

Phone:_____ **Alternate Phone:** _____

I certify that all of this information is true and correct and that all income is reported. I understand that this information is being given for the receipt of Federal funds; that Program officials may verify the information on the application and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal criminal laws.

Office use only: Total household size:_____ Total monthly household income $_____

Approved: ☐ Free ☐ Reduced

☐ Paid-Reason: ☐ Income over guidelines ☐ Incomplete ☐ Other

Signature of Eligibility Official_____ Date___/__/_____

State Use Only:

Verified By:_____

Verified Classification : ☐ Free ☐ Reduced ☐ Paid

Reason For Change _____

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Child Nutrition Program, Inc. Sponsor 7484

To Centers:

1. Aid parents in filling in name, date of birth, normal hours and days of care and normal meals.
2. If ethnic and racial ID. is not made, make a discreet visual assessment and record on the form.

3. Fax this form to us immediately upon receipt. 704-334-4060

Get this form to our office during a child's first month of enrollment or your reimbursement may be adversely effected.

Box B

Foster or Homeless Child (Including children evacuated From *Japan and Bahrain)

Indicate if child is a Foster Child or is homeless. Households with foster and non-foster children may choose to include the foster child as a household member, as well as any personal income earned by the foster child, on the same household application that includes their non-foster children. Additionally, when a host family applies for free and reduced price meals for their own children, the host family may include the homeless family as household members if the host family provides financial support to the homeless family. In such cases, the host family must also include any income received by the homeless family.

*Certification from the agency which assisted with the evacuation or is providing shelter is required.

Box C

Income information you give us will in no way reduce your benefits.

Any information you give us concerning income or ethnic and racial identity is confidential. and kept securely.

Box D

Check this table to see if your household income falls below these figures. Then, write your income in the table on the front.

The Department of Agriculture defines a household as a group of related or unrelated individuals (not residents of an institution or boarding house) who are living as one economic unit (i.e. sharing living expenses). The income which you report must be the total gross income, before deductions, received by all members of your household last month (i.e. wages, public assistance, TANF or retirement, etc.).

Household size	Weekly income	Monthly income	Yearly income	Household size	Weekly income	Monthly income	Yearly income
1	$459	$1,986	$ 23,828	5	$1,105	$4,786	$57,424
2	$620	$2,686	$32,227	6	$1,266	$5,486	$65,823
3	$782	$3,386	$40,626	7	$1,428	$6,186	$74,222
4	$943	$4,086	$49,025	8	$1,589	$6,886	$82,621
				Each additional person:	+$162	+$700	+$8,399

Net Income (before taxes or any other deductions) to report from last month in Box D:

Earnings from Employment
• Wage/salaries/tips • Strike benefits • Unemployment compensation • Net income from self-owned business or farm • Worker's compensation

Public Assistance/Child Support/Alimony
• Public assistance payments • TANF payments • Alimony/Child support payments

Pensions/Retirement/Social Security
Pensions • Supplemental security income • Retirement income • Veteran's payments • Social Security

Military Households
• All cash income, including military housing/uniform allowances. Does not include "in-kind" benefits NOT paid in cash (base housing, clothing, food, medical care, etc.)

Other Income
- Disability benefits
- Cash withdrawn from Savings
- Interest/dividends
- Income from estates/trusts/ investments
- Regular contributions from persons not living in the household
- Net royalties/annuities/ net rental income
- Any other income

To Parents:

We are a Sponsoring Organization for The Child and Adult Care Food Program. This Federal program supplements your Center's nutrition program. The goal of the food program is to support your Center in serving your children healthy meals. If you can supply income information on this form, it will help us all in assuring your children are given high quality meals. We are available to answer any questions you may have. If income changes during the year, you can amend this form any time.

704-375-3938 800-352-1547

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 your child for free or reduced price meals. You must include the last four digits of social security number if an adult household member who signs fills out the Household Income Information. The Social Security number is not required when you apply on behalf of a foster child or you list a Food Stamp, Temporary Assistance for Needy Families(TANF) for Food Distribution Program on Indian Reservations(FDPIR) case number for your child 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 your child is eligible for free or reduced price meals and for administration and enforcement of the Program. If a child is a Head Start participant, the child is automatically eligible to receive Program meal benefits, subject to submission by Head Start officials of a Head Start Statement of income eligibility or income eligibility documentation.

Parental Request For Non-Dairy Milk *OR* To Supply Approvable Milk

Any parent who requests a non-dairy milk substitution or requests to provide another approvable milk will complete this form.

1. _____ (PRINT) Center/ Provider Name
2. _____ (PRINT) Name of Child
3. _____ Parent Signature
4. _____ Date

Non-Dairy Milk Substitution Information:

Product must be nutritionally equivalent to milk and meet the nutritional standards for fortification of calcium, protein, vitamin A, vitamin D and other nutrients to levels found in cow's milk.

Below are the standards any product must meet. Call if you need help making determinations.

Per 8 ounce serving:

Calcium	>	=	28%	Magnesium	>	=	6%	Vitamin D	>	=	25%
Protein	>	=	8 g.	Phosphorus	>	=	22%	Riboflavin	>	=	26%
Vitamin A	>	=	10%	Potassium	>	=	10%	Vitamin B12	>	=	18%

Creditable choices below. Products may change; always check this chart.

Flavored Products Shown Below Can Only Be Served To Children who are 6 and older.

						
WESTSOY® Organic Plus Plain & Vanilla Soymilk	Silk Original Soymilk – half gallon container only	8th Continent Original or Vanilla Soymilk	Pacific Natural Ultra Soymilk Original or Vanilla	PEARL Organic Soymilk-Smart Original, Smart Creamy Vanilla, or Smart Chocolate	Great Value Original Soy Milk	Kirkland Signature™ Organic Plain Soymilk

Soy Milk

5. ☐ **Parent will supply Soy Milk.**

or

6. ☐ **Childcare will supply Soy Milk.**

7. **Reason for Soy Milk request (such as vegan or dairy allergy):** _____

8. **Product Name From Those Listed:** _____

or

Other Approvable Milk

9. ☐ **Parent requests to supply approvable milk product (such Organic Milk or Lactose Free Milk).**

10. **Type of product:** _____

Keep a copy on file and send one to us.

Center Name	Child and Adult Care Food Program (CACFP) Medical Statement for CACFP Participants Requiring Meal Modifications	Home Provider Name
_____		_____

Dear Parent/Guardian:
This institution/sponsor participates in the Child and Adult Care Food Program (CACFP) and must serve meals and snacks meeting the CACFP requirements. If a participant has a documented disability that restricts his/her diet, the institution/sponsor is required to provide substitutions as identified by a Licensed Physician. If a participant has a documented medical condition that restricts his/her diet, institution/sponsor must have a medical statement from a Licensed Physician or Recognized Medical Authority (Physician's Assistant or Nurse Practitioner), the institution/sponsor at their discretion may provide the substitution. Please have your Physician or Recognized Medical Authority complete and sign this form. Return the completed form to this institution/sponsor.

Participant Information		
1. Name:	2. DOB:	
Disability or Medical Condition		
3. The participant has a disability which restricts his/her diet: **If yes is checked, complete numbers 5 – 9 and sign on line 13**	☐ Yes	☐ No
4. The participant has a medical condition that restricts his/her diet: **If yes is checked, complete numbers 5, 8-9 and sign on line 14**	☐ Yes	☐ No
5. What is the disability/medical condition requiring modification of meals?		
6. Explain why disability restricts participant's diet:		
7. **Major life activity affected by disability: (Check all that apply)** ☐ caring for one's self ☐ performing manual tasks ☐ seeing ☐ hearing ☐ eating ☐ sleeping ☐ walking ☐ standing ☐ lifting ☐ bending ☐ speaking ☐ breathing ☐ learning ☐ reading ☐ concentrating ☐ thinking ☐ communicating ☐ working **Major bodily functions affected by disability: (Check all that apply)** ☐ functions of the immune system ☐ normal cell growth ☐ digestive ☐ bowel ☐ bladder ☐ neurological ☐ brain ☐ respiratory ☐ circulatory ☐ endocrine ☐ reproductive functions		

Substitutions	
8. Identify Foods to Omit from Diet:	**9. Identify Foods that may be Substituted in Diet:**

Other Special Dietary Needs		
10. The participant requires caloric modifications:	☐ Yes	☐ No
11. If yes, provide the caloric modification: _____ calories per day		
12. Other therapeutic diets (please explain):		
For a participant with a disability (If number 3 is checked yes, this form must be signed by a physician)		
13.Signature of Physician:	**Date:**	
For a participant with a medical condition		
14. Signature of Recognized Medical Authority:	**Date:**	

Instructions are on the reverse side

Instructions for Completing the
Medical Statement for CACFP Participants
Requiring Meal Modifications

Participant Information:

1. Provide the name of the participant who needs the modified meal.
2. Provide the date of birth of the participant.

Disability (formerly known as Handicapped Participant) or Medical Condition
7 CFR Subtitle A, Section 15b.3(i) Definitions:

3. The participant has a disability which restricts his/her diet: Check one. If yes is checked, complete numbers 5 through 9.
   (i) *A person with a "disability"* means any person who has a "physical or mental impairment which substantially limits one or more major life activities of such individual; has a record of such impairment or is regarded as having such an impairment."
   (ii) The Americans with Disabilities Act Amendments Act (ADAAA) broadened the list of "Major Life Activities" for purposes of identifying individuals with disabilities and added a new category called "Major Bodily Functions." As amended by the ADAAA, Major Life Activities now also include Major Bodily Functions.

4. The participant has a medical condition that restricts the participant's diet: Check yes or no. If yes is checked, complete numbers 5 and 8 through 9.

5. Briefly describe the disability or medical condition that necessitates the meal modification.

6. If the condition is a disability, explain why disability restricts participant's diet.

7. If the condition is a disability, indicate which major life activity is affected by disability. Major life activities include, but are not limited to caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. Check all major life activities that are affected by the disability. If the medical condition is not a disability leave this section blank.

Substitutions:

8. List the foods that must not be served to this participant.
9. For each food that must be omitted from the participant's diet list an alternate substitute that the participant is able to consume.

Other Special Dietary Needs:

10. Indicate whether the meal modification requires a caloric adjustment.
11. Indicate the type of caloric modification needed for the participant.
12. If the meal modification relates to a therapeutic diet or texture modification, please explain.

Health Care Provider Information:

13. If the meal modification is for a person with a disability, the institution/sponsor is required to make the modification and the form must be signed and dated by a physician.
14. If this meal modification is due to a medical condition not constituting a disability, the institution/sponsor is encouraged to make the substitution and the form must be signed and dated by a Recognized Medical Authority. (Physician, Physician Assistant, Nurse Practitioner)

North Carolina Department of Health and Human Services
Division of Public Health
Women's & Children's Health Section
Nutrition Services Branch
Child and Adult Care Food Program

Provision of Breastmilk or Infant Formula and Solid Foods

Institution/Facility Name:_____

Please select from the following choice(s):

☐ **I will breastfeed my infant on-site and/or provide expressed breastmilk.**

The Child and Adult Care Food Program (CACFP) encourages and supports breastfeeding. The American Academy of Pediatrics (AAP) recommends exclusively breastfeeding and/or provision of expressed breastmilk for six months; and continued breastfeeding after six months with the introduction of solid foods until at least one year. There is no age limit on breastfeeding or provision of expressed breastmilk. Mothers and infants/children may continue to breastfeed as long as mutually desirable. The North Carolina CACFP aims to help families meet their breastfeeding goals. For breastfeeding support, contact your county's Women, Infant, and Children (WIC) agency or visit www.zipmilk.org to find local breastfeeding resources.

☐ **I will accept the iron-fortified formula provided by the institution/facility.**

The facility offers: _____

Enter the name of the Iron-Fortified Infant Formula Provided by this institution/facility

I give permission for this institution/facility to prepare my infant's formula. When breastmilk is not available, infants must receive iron-fortified formula until 12 months of age. It is the parent's or guardian's choice to accept the formula provided by the institution/facility or provide an alternative formula.

***NOTE**: Infants receiving formula through the WIC Program are also eligible to receive formula from this center or day care home*

☐ **I decline the iron-fortified formula provided by the institution/facility**

I will provide my infant with the following formula: _____

NOTE: If providing formula, it must be iron-fortified. If the formula provided is a special formula, a medical statement will be requested.

☐ **When my infant is developmentally ready to accept solid foods and is around 6 months of age. I want the institution/facility to provide solid food(s) allowed under 7 § C.F.R. 226.20 (b) and policy memo 17-01.**

It is important to delay the introduction of solid foods until around 6 months of age as most infants are not developmentally ready to safely consume them. There is no single, direct signal to determine when an infant is developmentally ready to accept solid foods. An infant's readiness depends on his or her unique rate of development. Centers and day care homes should be in constant communication with parents/guardians about when and what solid foods should be served while the infants are in their care. The AAP provides the following guidance to help determine if your infant is ready for solid foods. Check below to show your agreement and understanding:

- ☐ When my infant can sit in a high chair, feeding seat, or infant seat with good head control.
- ☐ When my infant is watching me and others eat, reaching for food, and seems eager to be fed.
- ☐ When my infant can move food from a spoon into the throat and does not push it out of the mouth and/or dribbles onto his or her chin.
- ☐ When my infant has doubled his or her birth weight and weighs around 13 pounds or more.

Infant's Name: _____

Infant's Date of Birth:_____/_____/_____

Parent/Guardian Signature: _____ Date: _____/_____/_____

***NOTE TO PARENTS:** When a parent or guardian chooses to provide breastmilk (expressed breastmilk or breastfeed on-site) or a creditable infant formula and the infant is consuming solid foods, the center or day care home must supply all other required meal components for the meal to be reimbursable.*

***NOTE TO INSTITUTION/FACILITY:** This document is required for all enrolled infants.*