



# Provider Resources Inc. CACFP Child Enrollment Form

New  Updated

For questions please contact: Provider Resources Inc. 411 Merrimack St STE 100, Methuen, MA 01844 781-939-9292

PROVIDER'S NAME \_\_\_\_\_ SITE # \_\_\_\_\_

Dear Parent/Guardian:

Your **Family Day Care Provider** participates in the United States Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP) administered by the Massachusetts Department of Elementary and Secondary Education.

Meals served must meet nutrition requirements established by USDA's Child & Adult Care Food Program. In order to participate, your Provider has agreed to follow the USDA guidelines. The Provider will give you a copy of the minimum meal components and portion requirements to be served according to the child's age. A medical statement from your doctor is necessary if your child cannot eat foods required by the CACFP. In an effort to assess that these requirements are being met, the USDA and CACFP requires providers to annually collect the enrollment information listed below. **Please complete the form and return it to your Family Day Care Provider.**

CHILD # ASSIGNED _____		PART 1: CHILD ENROLLMENT INFORMATION		
Child's First Name	MI	Last Name	Child's Date of Birth & Age	Beginning Date of Child Care
<b>Normal times in care</b> For example 7:30 AM – 5 PM Earliest drop off and latest pick up		<b>Hours from:</b> _____ to _____		<b>Check the days your child normally attends</b> <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
<b>Check meals your child receives while in normal times in care</b> <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"/> Evening Snack		<input type="checkbox"/> Check here <b>IF Schedule Varies &amp; select additional alternative days</b> <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
<b>School Age Child / Times child attends school</b> For example 8:00 AM – 3:00 PM _____ to _____			<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>Child attends full day during school closures:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, fill out below		<b>Relation: Child's relation to the provider</b> <input type="checkbox"/> Not Related <input type="checkbox"/> Related –Non Resident <input type="checkbox"/> Provider's Foster child* <input type="checkbox"/> Provider's Own child**		
<b>Times in care during Vacation or No School days</b> Earliest drop off and latest pick up _____ to _____		<input type="checkbox"/> Breakfast <input type="checkbox"/> AM Snack <input type="checkbox"/> Lunch		
<b>Check meals your child receives on school vacation or no school day</b> <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"/> Evening Snack		
<b>(IF enrolling an INFANT [Birth – 11 months old], complete this section to provide the best nutritional care for your Infant.)</b>				
<input type="checkbox"/> <b>This child is Breast-fed</b> <input type="checkbox"/> I will supply expressed breast milk <input type="checkbox"/> Provider will supply Formula		<input type="checkbox"/> <b>This child is Formula-fed</b> <input type="checkbox"/> I will supply Formula <input type="checkbox"/> Provider will supply Formula		<b>Name of Iron Fortified Infant Formula:</b> _____ <b>IF the Provider supplies Formula:</b> <input type="checkbox"/> I also wish to supply ONE other creditable food item <b>Name of Item:</b> _____

Nutritious meals meeting the United States Department of Agriculture guidelines are served to all children enrolled in this program, including children under the age of 12 months. The Provider must meet the meal component requirements based on age and developmental readiness as outlined in the Infant Meal Pattern. **Parents/Guardians may supply not more than one component in the meal pattern (including breast milk or formula) in order for the meal to be reimbursable in CACFP.**

## PART 2: PARENT OR GUARDIAN ACCEPTANCE AND SIGNATURE

PARENT OR GUARDIAN NAME \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
 MAILING ADDRESS: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

*I have read this child enrollment form and I **DO** request that my child receive the above CACFP benefits. I have received a copy of this completed form and the "Building For The Future" Flyer. Also, as applies, I understand that this Family Day Care Provider will supply infant cereal and infant foods for infants 4 months and older as they are developmentally ready according to the CACFP requirements.*

*I have read this child enrollment form and I **DO NOT** request that my child receive the above CACFP benefits.*

\_\_\_\_\_  
**PARENT OR GUARDIAN SIGNATURE**

\_\_\_\_\_  
**DATE (must be renewed annually)**

<b>CIVIL RIGHTS:</b> This information is voluntary and will not affect your children's eligibility. Please indicate the ethnic and racial identity of your children by checking a box in each of the categories. This information is being collected to assure that everyone receives CACFP benefits on a fair basis.			
<b>1. Ethnic Identity</b>		<input type="checkbox"/> HISPANIC OR LATINO <input type="checkbox"/> NOT HISPANIC OR LATINO	
<b>2. Racial Identity</b>		<input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> WHITE <input type="checkbox"/> ASIAN	

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. 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 online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](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](mailto:program.intake@usda.gov). This institution is an equal opportunity provider. This project has been funded at least in part with Federal funds from the US Department of Agriculture

**FOR SPONSOR OFFICE USE ONLY** Effective Date of this Enrollment Form: \_\_\_\_\_  
 Fiscal Year \_\_\_\_\_

THE EFFECTIVE DATE CAN BE MADE RETROACTIVE BACK TO THE FIRST DAY THE CHILD PARTICIPATES IN THE CACFP AS LONG AS IT OCCURS IN THE SAME MONTH THIS FORM IS RECEIVED.