This form MUST be filled out by ALL enrolling families regardless of income. S&G is reimbursed a portion of our food costs from the government for every child in care regardless of household income.

Household Income Eligibility Statement – Child Care Institutions

Part 1 – **Households Receiving Food Assistance Program (FAP), Family Independence Program (FIP), or Food Distribution Program on Indian Reservations (FDPIR)**

If any member of your household receives FAP, FIP, or FDPIR, provide the name and case number for the person who receives the benefits.

Name: _____ **Case Number:** ___ ___ ___ ___ ___ ___ ___ ___ ___

Part 2 – ALL HOUSEHOLDS

First and Last Names of All Household Members, Related and Unrelated	Enrolled for Child Care (x)	Age	Birth Date	Foster Child (x)	Amount of Earnings from Work (before deductions)	How Often? (x) Annually	Monthly	2xMonth	BiWeekly	Weekly	Amount of Welfare, Child Support, or Alimony	How Often? (x) Annually	Monthly	2xMonth	BiWeekly	Weekly	Amount of All Other Income (Indicate source and amount)	How Often? (x) Annually	Monthly	2xMonth	BiWeekly	Weekly	Mark if No Income (x)

Part 3 – ALL HOUSEHOLDS: Signature and Last Four (4) Digits of Adult Social Security Number (Adult household member MUST sign and date)

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 receive 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.

Signature: _____ Print Name: _____ Date: _____

Last four digits of Social Security Number: XXX-XX-_ _ _ _ ____ I do not have a Social Security Number

For Institution Use Only:

For Institution Use Only		
Total Household Members:	Total Income: $ ___ Annually ___ Monthly ___ 2x Month ___ Bi-Weekly ___ Weekly	APPROVED CATEGORY Categorical Eligibility (A/Free): Foster FIP FAP FDPIR Other Household Children: A (Free) B (Reduced) C (Paid)
Institution Official Signature: _____ Approval Date: _____		

This form is valid for 12 months from the date of institution signature. Approval date and institution signature are required.

TURN OVER

Return this completed form to: ***(Scribbles & Giggles Child Care 609 N. Verlinden Ave Lansing, MI 48915 517-482-1551)***

Participant Enrollment Form

Instructions:

1. List full name of participant enrolled in care
2. Circle the typical days each participant is in care
3. List times each participant is in care
4. Circle the meals and snacks each participant typically receives while in care
5. Select the ethnicity of each participant using the following codes: H = Hispanic or Latino, N = Not Hispanic or Latino*
6. Select one or more racial designations of each participant using the following codes: A/I = American Indian or Alaskan Native, A = Asian, B = Black or African American, H/PI = Native Hawaiian or Pacific Islander, W = White*
7. Sign and date the form and return to your care center

Participant's First and Last Name	Typical Days in Care (circle all that apply)	List Times in Care	Meals/Snacks Received (circle all that apply)	Ethnicity	Race
	Mon Tues Wed Thurs Fri		Breakfast AM Snack Lunch		
	Mon Tues Wed Thurs Fri		Breakfast AM Snack Lunch		
	Mon Tues Wed Thurs Fri		Breakfast AM Snack Lunch		
	Mon Tues Wed Thurs Fri		Breakfast AM Snack Lunch		

* This information is voluntary. This will assist us in assuring the Child and Adult Care Food Program is administered in a nondiscriminatory manner.

_____ Adult/Parent/Guardian's Address

_____ Adult/Parent/Guardian's Phone Number

_____ Signature of Adult/Parent/Guardian

_____ Date Signed

Non-Discrimination Statement

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) (http://www.ascr.usda.gov/complaint_filing_cust.html) online, 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. This institution is an equal opportunity provider.