

Dear Parent or Guardian:

Our child care institution has been approved by the Nebraska Department of Education for participation in the Child and Adult Care Food Program (CACFP). The CACFP reimburses our institution for the partial cost of meals. We are requesting your help to receive the maximum benefits from the CACFP by completing the attached form (NS)100-C.

The parent/guardian must complete Parts 1 and 4 and one of the following options: Part 2, Part 3A or Part 3B, to determine the amount of CACFP funds the center will be eligible to receive. **Note: No white out or erasure ink should be used.** If there is an error cross through, correct, and initial.

Part 1 - CHILD ENROLLMENT

- **Child's Name:** List the first and last name including nicknames and hyphenated last name for all children enrolled at this center.
- **Date of Birth:** List each child's date of birth.
- **Enroll Date:** List each child's enrollment date with the organization.
- **Usual Times & Days of Care and Meals Served:** List the usual times of care for each child by listing their arrival and leave time, check each day the child will be in care and each meal type received while in care.
- **Infant:** If the child is under 12 months of age, check box.
- **Foster Child:** If the child is a foster child (the legal responsibility of a foster care agency or the court), check the box.
- **Head Start:** If the child is eligible for head start, check box.
- **School age:** If the child is attending Kindergarten or above and attends your child care program before, after and/or school days off, check box.

Optional – Check the boxes of all appropriate race(s) and ethnicities regarding the child(ren) you are enrolling. If you do not select Race or Ethnicity, one will be selected for you based on visual observation. This does not affect your child's eligibility for Free or Reduced meals.

Part 2 – Household Receiving Benefits from the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR):

- Complete Parts 1, 2 and 4 on the attached form.
- Check the box(s) and provide case number for the program from which benefits are received.

Part 3A – Household exceeding the income guidelines listed on the chart below - Complete Parts 1, 3A and 4 on the attached form.

TO CALCULATE ANNUAL INCOME

Weekly Income X 52 ♦ Every 2 Weeks Income X 26 ♦ Twice a Month Income X 24 ♦ Monthly Income X 12

Household Size:	1	2	3	4	5	6	7	8	Each Additional Family Member
Annual Income:	\$22,459	\$30,451	\$38,443	\$46,435	\$54,427	\$62,419	\$70,411	\$78,403	+ \$7,992

Part 3B - Household below the income guidelines listed on the chart above - Complete Parts 1, 3B and 4 on the attached form using the additional information below:

- **HOUSEHOLD NAMES:** Write the names of everyone in the household not listed in Part 1. Include yourself and all other children, your spouse, grandparents, other relatives and unrelated people in your household. Use a separate sheet of paper if you do not have enough space.
- **GROSS INCOME BEFORE DEDUCTIONS:** Write the amount of income each person gets on the same line as their name. Use the appropriate column(s): Earnings from Work, Welfare/Child Support/Alimony, Pensions/Retirement/Social Security or Other Income (see definitions below). Next to the amount of income write how often the income is received. Income is all money before taxes or anything else is taken out. If a person does not have income, check the box for zero income.

OTHER INCOME: strike benefits, unemployment compensation, workman's compensation, disability benefits, interest/dividends, cash withdrawn from savings, income from estates/trust/investments, royalties/annuities/rental income, and regular contributions from persons not living in the household.

FOSTER CHILDREN: List any personal income received by the foster child under Part 3B. Personal income is (a) money given for the child's personal use, such as clothing, school fees and allowances and (b) all other money the child gets, such as money from his/her family.

MILITARY HOUSING BENEFITS: Report off-base housing allowance as income. If the housing is part of the Military Housing Privatization Initiative, do not include as income.

SELF-EMPLOYMENT: Report income derived from the business venture less operating costs for net income. The loss from the business cannot be deducted from a positive income earned in other employment. The least possible income is zero.

- **SOCIAL SECURITY NUMBER:** Write the last four (4) digits of the social security number of the adult household member who signs the form. If the adult household member does not have a social security number, check the box. Use of this information is for CACFP use only and is required.

Part 4 SIGNATURE AND CONTACT INFORMATION:

- Sign and date the application. The form must be signed by the parent or guardian.
- Complete the contact information – name, address, e-mail address and telephone number.

Privacy Act Statement:

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, the funds your child care/center/provider receives may be impacted. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant 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 the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

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) found online 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.

This institution is an equal opportunity provider.

As stated above, all protected bases do not apply to all programs, "*the first six protected bases of race, color, national origin, age, disability and sex are the six protected bases for applicants and recipients of the Child Nutrition Programs.*"

For assistance completing this form, contact the center:

E-Mail Address: _____

Center Name: _____

The State Agency administering the Child and Adult Care Food Program is:

Address: _____

Nebraska Department of Education
Nutrition Services
P.O. Box 94987

City, State, Zip: _____

Lincoln, NE 68509

Contact Person: _____

Telephone: 402-471-2488

Telephone: _____

Web site: <http://www.education.ne.gov/NS>

**INCOME ELIGIBILITY & ENROLLMENT FORM FOR CHILD CARE CENTERS
JULY 1, 2018 THROUGH JUNE 30, 2019**

Part 1. CHILD ENROLLMENT: Complete the information below for all children in care. If the child is an infant, foster child (legal responsibility of a foster care agency or the court), Head Start eligible or a school-age child, please check the box.

Last Name, First Name	Date of Birth	Enroll Date	Times of Care (Usual)		Usual Days of Care							Meals Served During Care					Infant	School Age	Head Start	Foster Child		
			Arrival Time	Leave Time	M	T	W	T	F	S	S	B	A M	L	P M	D					E V	
																			<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"/>

OPTIONAL: Please check the ethnicity and race of the child(ren) you are enrolling.

Ethnicity (select one or more): Hispanic or Latino Not Hispanic or Latino

Race (select one or more): American Indian or Alaskan Native Asian Black or African American

Native Hawaiian or other Pacific Islander White or Caucasian

Part 2. Household Receiving Benefits: Supplemental Nutrition Assistance Program (**SNAP**), Temporary Assistance for Needy Families (**TANF**), or Food Distribution Program on Indian Reservations (**FDPIR**): **Complete Parts 1, 2 and 4.**

Check Applicable Program(s): SNAP TANF FDPIR Master Case #: _____

Part 3A. HOUSEHOLDS EXCEEDING THE INCOME GUIDELINES: Complete Parts 1, 3A and 4.

If your family income exceeds the income guidelines (listed on attached letter), check this box

Part 3B. ALL OTHER HOUSEHOLDS – If you **do not** have a SNAP, TANF or FDPIR **MASTERCASE** number: Complete Parts 1, 3B and 4.

List the Names of All Household Members not listed in Part 1 and Foster Children	GROSS INCOME BEFORE ANY DEDUCTIONS (Net for Self Employed) W=Weekly E2=Every 2 weeks 2M=Twice monthly M=Monthly Y=Yearly										Check If ZERO income	
	Earnings from Work		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		All Other Income					
	How much?	How often?	How much?	How often?	How much?	How often?	How much?	How often?	How much?	How often?		
1												<input type="checkbox"/>
2												<input type="checkbox"/>
3												<input type="checkbox"/>
4												<input type="checkbox"/>

Social Security Number of Household Member who signs form:

Last four digits of Social Security Number: XXX-XX -_____ If you do not have a Social Security Number, check this box

Part 4. SIGNATURE AND CONTACT INFORMATION:

I certify (promise) that all information on this form is true and that all income is reported. I understand that the facility 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 their meal benefits, and I may be prosecuted.

Signature of Parent/Guardian _____ Date _____

Print Name _____

Address _____

City _____ State _____ Zip Code _____

E-Mail Address/Telephone _____

FOR CENTER USE ONLY

____ SNAP/TANF/FDPIR HOUSEHOLD

____ ANNUAL INCOME: _____ HOUSEHOLD SIZE: _____

Center Official Signature _____ Date of Signature _____

Effective Date _____ Expiration Date _____

HOUSEHOLD CATEGORY:	<input type="checkbox"/> Free
	<input type="checkbox"/> Reduced
	<input type="checkbox"/> Paid
	<input type="checkbox"/> Incomplete
Foster Child – Free Category	
List name of foster child(ren)	
