Dear Parent or Guardian:
Our childcare 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. *All information contained in this form is* ***confidential.***

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 names 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 childcare 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:	$29,526	$40,034	$50,542	$61,050	$71,558	$82,066	$92,574	$103,082	+ $ 10,508

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 childcare/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 (including gender identity and sexual orientation), 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) 6329992. 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.

For assistance completing this form, contact the center:

Center Name:_____

Address: _____

City, State, Zip: _____

Contact Person:_____

E-Mail: _____

Telephone: _____

The State Agency administering the Child and Adult Care Food Program is:
Nebraska Department of Education
Nutrition Services
P.O. Box 94987
Lincoln, NE 68509
Telephone: 402-471-2967
Website: http://www.education.ne.gov/NS

INCOME ELIGIBILITY & ENROLLMENT FORM FOR CHILD CARE CENTERS
JULY 1, 2026 THROUGH JUNE 30, 2027

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 appropriate box.

Last Name, First Name	Date of Birth	Enroll Date	Times of Care (Usual)		Days in Care (Usual)							Meals Served During Care						Infant	School age	Head Start	Foster Child
			Arrival Time	Leave Time	M	Tu	W	Th	F	Sa	Su	B	AM	L	PM	D	EV	(Zero -11 months)			
																		❑	❑	❑	❑
																		❑	❑	❑	❑
																		❑	❑	❑	❑
																		❑	❑	❑	❑

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

Check Applicable Program & Provide a Master Case Number(s): ❑ SNAP Case #:_____ ❑ TANF Case #:_____ ❑ FDPIR Case #:_____

Part 3A. Households **exceeding** the income guidelines (listed on the attached letter), check this box. ❑

Part 3B. All other households – If you do not have a SNAP, TANF or FDPIR *master case* number. Complete Parts 1, 3B and 4.

List the names of **ALL** household members not listed in **Part 1 & foster children.**	REPORT GROSS INCOME BEFORE ANY DEDUCTIONS (Net for Self-Employed) **Frequency of pay codes – 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 (see instructions)**		
	How much	How often	How much	How often	How much	How often	How much	How often	
									❑
									❑
									❑

Last four digits of the Social Security Number of Household Member who signs this form: **XXXX-XX-**_____ If you do not have a Social Security Number, check this box: ❑

Part 4 Signature and Contact Information
I certify (promise) that all the 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 Official may verify the information. I understand that if I purposely give false information the participant receiving meals may lose their benefits, and I may be prosecuted.

_____ _____
Signature of Parent/Guardian **Date of Signature**

Optional: Parent/Guardian Contact Information:

_____
Print Name

_____
Address ***City*** ***State*** ***Zip***

E-Mail Address: _____ ***Telephone:*** _____

Center Use Only

_____ SNAP/TANF/FDPIR Household (must have a master case #)

_____ Annual Income: $ _____ Household Size _____

_____ _____
Center Official Signature Date of Signature

_____ _____
Effective Date Expiration Date

Household Meal Benefit Category:
- ❑ Free
- ❑ Reduced
- ❑ Paid
- ❑ Incomplete

Foster Child – Free Category
List names of foster child(ren):_____