

July 2023

Dear Families:

Little Sprouts offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture's Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to **ALL** children enrolled, regardless of income level.

Attached, you will find two forms related to the state of Massachusetts USDA Food Program:

- Annual Food Program Child Enrollment Form
- Annual Food Program Meal Benefit Eligibility Form

In order for us to remain compliant in the USDA food program and continue providing nutritious snacks to enrolled children, **we require all enrolled families to fill out both forms.**

1. **Meal Benefit Eligibility Form:** Although this form is mandatory, families are not required to provide income information if they do not feel comfortable doing so. Please feel free to leave the income section blank or write "refused." Please fully fill out the remainder of the form.
2. **Child Enrollment Form:** This is a mandatory form that requests basic information. We are required by the USDA to collect Meal Benefit Enrollment Forms from parents and guardians of any child who attends Little Sprouts, whether the family qualifies or not. This form is separate from the one above.

Please fill out the two attached forms and return to your school director. Should you have any questions, please do not hesitate to reach out to your school director.



**Massachusetts Department of Elementary and Secondary Education (DESE)
Office for Food and Nutrition Programs**

**Child Enrollment Documentation Requirement
Child and Adult Care Food Program – Child Care Centers**

Child Care Centers that participate in the Child and Adult Care Food Program (CACFP) are required to annually collect enrollment information from parents and guardians.

Documentation of enrollment must include:

- Each enrolled child's normal days and hours in care and the meal services in which each child normally participates
- Signature of parent or guardian
- Annual updating of the information.

7 CFR 226.15(e)(2) & 226.17(b)(7)

To document enrollment information, child care centers may use the attached CACFP Enrollment Forms or adapt their own form. An adapted form must incorporate the same questions and their intent from the DESE Child Enrollment Form. Sponsors and centers electing to revise the enrollment form must submit a copy to DESE for review and approval prior to use and distribution.

The parent/guardian must complete the form in full with current information, sign, and date the form.

Centers may not claim reimbursement for any participant without a parent/guardian signed enrollment form (new or renewal) on file. Each child enrollment form is effective for a maximum of one year.

Sponsors and centers must perform edit checks for clerical accuracy confirming data entered on all child enrollment forms.

If you have any question about the requirement for collection of enrollment information, please contact DESE Special Nutrition Services at 781-338-6480.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotope, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or
2. **fax:**
(833) 256-1665 or (202) 690-7442; or
3. **email:**
program.intake@usda.gov

This institution is an equal opportunity provider.

Child Enrollment Form

Child & Adult Care Food Program

Dear Parent/Guardian:

Your child care center _____ 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, the child care center has agreed to follow the USDA guidelines. 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 child care centers to annually collect the enrollment information listed below.

Please complete the form and return it to your child care center. Part 1 and Part 3 need to be completed by all families or guardians. Part 2 is to be completed ONLY if enrolling an infant child (under the age of 12 months).

PART 1: CHILD ENROLLMENT INFORMATION

Child's First Name	Last Name	Child's Date of Birth & Age	Beginning Date of Child Care
Times Child Normally Attends For example 7:30 AM – 5 PM <input checked="" type="checkbox"/> Box <input type="checkbox"/> Schedule Varies	Hours from: _____ to _____ _____ to _____	Check the days your child normally attends <input type="checkbox"/> Sunday <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday	Check the meals you request that your child receives while in care <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

Child's First Name	Last Name	Child's Date of Birth & Age	Beginning Date of Child Care
Times Child Normally Attends For example 7:30 AM – 5 PM <input checked="" type="checkbox"/> Box <input type="checkbox"/> Schedule Varies	Hours from: _____ to _____ _____ to _____	Check the days your child normally attends <input type="checkbox"/> Sunday <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday	Check the meals you request that your child receives while in care <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

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If there are other children in care, please complete additional forms as needed.

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.

PART 2: INFANT MEAL NOTIFICATION (Birth through 11 months)

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 child care center must meet the meal component requirements based on age and developmental readiness outlined in the Infant Meal Pattern. **Parents/Guardians may supply not more than one required component per meal in the meal pattern (including breast milk or formula) in order for the meal to be reimbursable in CACFP.**

I understand that this child care center has available the iron fortified formula _____ for my infant while in care.
(Name of Iron Fortified Infant Formula)

To help provide the best nutritional care for your infant, please complete the following information.

PLEASE CHECK ONE OPTION (Breast Milk / Formula):

☐ I will supply expressed (pumped) breast milk for my infant child and/or breast feed at center. **OR** I will supply formula for my infant child.

☐ I prefer to have the center supply the formula offered.

PLEASE CHECK ONE OPTION (Food Items):

☐ I will supply all food items for my infant's meals. I decline food items provided by the provider/center.

☐ I have elected to have the provider/center supply the formula and I wish to provide one food item. I will provide the following one creditable food item: _____

☐ I would like provider/center to provide all food items for my infant's meals.

PART 3: PARENT OR GUARDIAN ACCEPTANCE AND SIGNATURE

I have read this child enrollment form and request that my child receive the above Child and Adult Care Food Program benefits. I have received a copy of this completed form.

Parent's Signature

Date Signed (form must be completed annually)

Parent's Name:

:

Please Print

Home Phone:

Mailing Address:

Work Phone:

City, State, Zip:

Cell Phone:

CIVIL RIGHTS: 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.

1. **Ethnic Identity** ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO.

2. **Racial Identity** ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN

☐ NATIVE HAWAIIAN or OTHER PACIFIC ISLANDER ☐ WHITE.

For questions please contact: Sponsor or Child Care Center, Contact Name, Address, and Telephone Number

This institution is an equal opportunity provider.



CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members				
Name of Enrolled Child(ren):				
Names of all household members (First, Middle Initial, Last)		CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.		CHECK IF NO INCOME
		<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"/>
Part 2. Benefits: If any member of your household received SNAP or TAFDC cash assistance, provide the name and case number for the person who receives benefits. If no one receives these benefits, skip to part 3. NAME: _____ CASE NUMBER: _____				
Part 3. If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call the Child Care Sponsor at Phone #: Homeless <input type="checkbox"/> Migrant <input type="checkbox"/> Runaway <input type="checkbox"/>				
Part 4. Total Household Gross Income—You must tell us how much and how often				
A. Name (List only household members with income) (Example) Jane Smith	B. Gross income and how often it was received			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
	\$200/weekly	\$150/twice a month	\$100/monthly	\$ /
	\$ /	\$ /	\$ /	\$ /
	\$ /	\$ /	\$ /	\$ /
	\$ /	\$ /	\$ /	\$ /
	\$ /	\$ /	\$ /	\$ /
	\$ /	\$ /	\$ /	\$ /
Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign) An adult household member must sign this form. If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the “I do not have a Social Security Number” box. (See Privacy Act Statement on the back of this page.) <i>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 get 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.</i> Sign here: _____ Print name: _____ Date: _____ Address: _____ Phone Number: _____ City: _____ State: _____ Zip Code: _____ Last four digits of Social Security Number: _*_*_* - _*_*_* - _____ <input type="checkbox"/> I do not have a Social Security Number				



CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

CACFP Meal Benefit Income Eligibility
Child Care Form

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Part 6. Participant's ethnic and racial identities (optional)	
Mark one ethnic identity:	Mark one or more racial identities:
<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander
Don't fill out this part. This is for official use only.	
Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12	
Total Income: _____ Per: <input type="checkbox"/> Week, <input type="checkbox"/> Every 2 Weeks, <input type="checkbox"/> Twice A Month, <input type="checkbox"/> Month, <input type="checkbox"/> Year Household size: _____	
Categorical Eligibility: _____ Eligibility: Free _____ Reduced _____ Denied _____	
Reason: _____	
Determining Official's Signature: _____ Date: _____	
Confirming Official's Signature: _____ Date: _____	

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

Effective July 1, 2023 to June 30, 2024	
Household size	Yearly
1	26,973
2	36,482
3	45,991
4	55,500
5	65,009
6	74,518
7	84,027
8	93,536
Each additional person:	+9,509

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, we cannot approve the participant for free or reduced price meals. 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.



CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

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To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or
2. **fax:**
(833) 256-1665 or (202) 690-7442; or
3. **email:**
program.intake@usda.gov

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SHARING INFORMATION WITH MEDICAID/CHIP

Dear Parent/Guardian:

If your children qualify for free or reduced price meals, they may also be able to get low to no cost health insurance through Medicaid or the Children's Health Insurance Program (CHIP). Children with health insurance are more likely to get regular health care and are less likely to become sick.

Because health insurance is so important to children's well-being, **the law allows us to tell Medicaid and CHIP that your children are eligible for free or reduced price meals, unless you tell us not to.** Medicaid and CHIP only use the information to identify children who may be eligible for their programs. Program officials may contact you to offer to enroll your children in this health insurance program. Filling out the CACFP Meal Benefit Income Eligibility Forms does not automatically enroll your children in health insurance.

If you do not want us to share your information with Medicaid or CHIP, fill out the form below and send it with your Income Eligibility Form to **[address]** by **[date]**. (Sending in this form will not change whether your children get free or reduced price meals.).



No! I DO NOT want information from my CACFP Meal Benefit Income Eligibility Form shared with Medicaid or the Children's Health Insurance Program.

If you checked no, fill out the form below.

Child's Name: _____

Child's Name: _____

Child's Name: _____

Child's Name: _____

Signature of Parent/Guardian: _____

Today's Date: _____

Print Your Name: _____

Address: _____

For more information, you may call **[name]** at **[phone]**

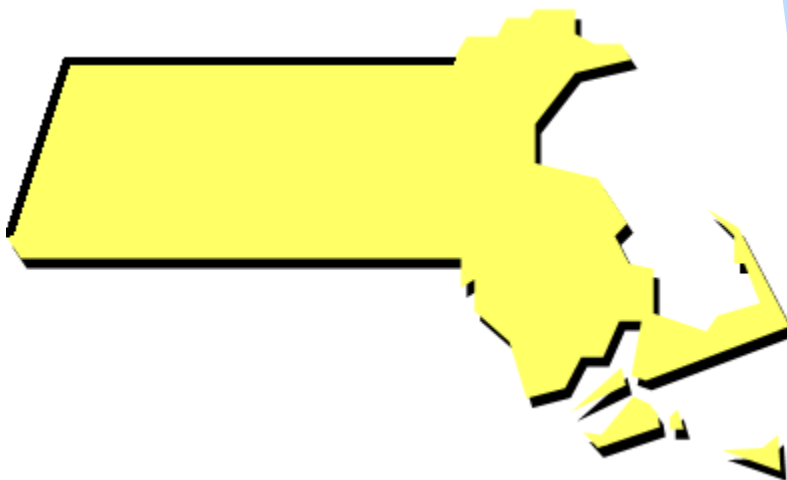


If your child is eligible for free or reduced school meals, your child may also be eligible for
free or low cost health insurance

through MassHealth.

To learn more call: 1-800-841-2900

MassHealth



Si su niño es eligible para almuerzo gratis o reducido, su niño pueda ser eligible para
seguro de salud gratis o de bajo costo
por medio de MassHealth.

Para saber mas, llame al: 1-800-841-2900

**Covering
Kids**

