KNP Number:_______________

Karamu Nutrition Program Inc.

INFANT FORMULA STATEMENT

Dear Parent:

This child care facility participates in the USDA's Child & Adult Care Food Program (CACFP). The CACFP provides reimbursement to the child care facility for nutritious meals served to your child while in care. Under CACFP regulations, the child care provider may not charge you a separate fee for meals that are claimed for reimbursement.

Below are the USDA's meal pattern requirements for infants participating on the CACFP. These requirements show the types and amounts of foods to be served to your infant while in care.

Age	Breakfast	Lunch and Supper	Snack
Birth through 5 months	4-6 fluid ounces formula or breast milk	4-6 fluid ounces formula or breast milk	2-4 fluid ounces formula or breast milk
6-11 months	6-8 fluid ounces formula or breast milk and 0-4 tablespoons infant cereal, meat, fish, poultry, whole egg, cooked dry beans or cooked dry peas; or 0-2 ounces of cheese; or 0-4 ounces of cottage cheese; or 0-4 ounces or ½ cup yogurt; or a combination of the above and 0-2 tablespoons vegetable or fruit or a combination of both	6-8 fluid ounces formula or breast milk and 0-4 tablespoons infant cereal, meat, fish, poultry, whole egg, cooked dry beans or cooked dry peas; or 0-2 ounces of cheese; or 0-4 ounces of cottage cheese; or 0-4 ounces or ½ cup yogurt; or a combination of the above and 0-2 tablespoons vegetable or fruit or a combination of both	2-4 fluid ounces formula or breast milk and 0-1/2 slice bread or 0-2 crackers; or 0-4 tablespoons infant cereal or ready-to-eat breakfast cereal and 0-2 tablespoons vegetable or fruit or a combination of both

As part of offering a meal that is compliant with the CACFP infant meal pattern requirements, child care facilities with infants in their care must offer at least one type of iron-fortified infant formula. Parents or guardians may, at their discretion, decline the infant formula offered by the child care facility and provide breastmilk or a creditable infant formula instead.

____

(Name of Daycare)

Currently provides the following iron-fortified infant formula: ____

Please fill out the form below with your preference for formula served to your infant.

MUST BE COMPLETED BY PARENT/GUARDIAN

Infant's Name ____ **Birthdate** ____/____/____

___ Parent accepts the iron fortified infant formula provided by the daycare

___ Parent will supply iron fortified infant formula

___ Parent will supply breastmilk

____ ______________________

Parent/Guardian Signature **Date**

If you have questions, feel free to ask your childcare provider or contact Karamu Nutrition at 901.327.8401.

CACFP Consolidated Enrollment & Income Eligibility Application

Karamu Nutrition Program

CENTER NAME:____ **KNP#: C**____________

Part 1. Children Enrolled For Care

Names of Enrolled Child(ren) (First, Middle Initial, Last)	**Date of Birth**	***FOSTER CHILD**	**DAYS NORMALLY IN CARE** (CIRCLE)	**TIMES NORMALLY IN CARE**			**MEALS NORMALY FED** (CIRCLE)
	/ /	☐	M – F SA SU		to		B A L P D E
	/ /	☐	M – F SA SU		to		B A L P D E
	/ /	☐	M – F SA SU		to		B A L P D E
	/ /	☐	M – F SA SU		to		B A L P D E
	/ /	☐	M – F SA SU		to		B A L P D E

*Foster child must be the legal responsibility of a welfare agency or court. If all children listed above are foster children, skip to part 5 to sign this form.

******IF YOU ARE USING THIS FORM FOR CHILD ENROLLMENT ONLY, SKIP TO PART 5.*******

Part 2. Benefits: Households which are currently receiving benefits through the Supplemental Nutrition Assistance Program (SNAP) or Families First (FF) Cash Assistance or Families First Child Care Assistance (If your household is now receiving benefits under one or more of these programs, complete this part, and sign the statement in Part 5 – Do not complete Part 4.)

ACCENT Case No. for SNAP or FF Cash Assistance: ________________ (7 to 10 digits) OR **FF Child Care Assistance Case No.**: ________________ (5 to 9 digits)

Part 3. Other Source Categorical Eligibility If any child you are applying for is homeless, migrant, runaway, or participates in Headstart, provide their name(s) and check the appropriate box. Documentation certifying the child's status must be provided with this application.

Homeless ❑ Migrant ❑ Runaway❑ Headstart ❑

Part 4. Total Household Gross Income

A. Name (List **all** household members not listed above. List children from Part 1 only if they have reportable income)	**B. Gross Annual Income** (Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12) 1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
	$ per Year	$ per Year	$ per Year	$ per Year
	$ per Year	$ per Year	$ per Year	$ per Year
	$ per Year	$ per Year	$ per Year	$ per Year
	$ per Year	$ per Year	$ per Year	$ per Year
	$ per Year	$ per Year	$ per Year	$ per Year

Part 5. Signature and Last Four Digits of Social Security Number (Adult household member 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.**

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.

Sign here: ______________________________ Print name: ______________________________

Date: ______________

Last four digits of Social Security Number: (Only if reporting income in Part 4) __ __ __ __ ❑ I do not have a Social Security Number

Address: ______________________________________ Phone Number: __________________

City: ________________________ State: _____ Zip Code: _________ Email Address: ________________________

Part 6. Participant's Ethnic and Racial Identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:
❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ Asian ❑ White ❑ Black or African American ❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander

DO NOT WRITE BELOW THIS LINE – KARAMU STAFF USE ONLY

Eligibility Classification: (Circle) Free Reduced-Price Paid **Basis for Classification: (Circle)** Categorically Eligible Income Eligible

Determining Official Signature: ______________________________ Date: ______________

Instructions

Part 1: List the name, date of birth, days, and times normally in care, and meals normally fed for all children from the household that are enrolled for care in the center.

If this form is being used for child enrollment only and you choose to not provide household income information, then skip to part 5.

Note: If you refuse to provide household income information, your childcare provider may not qualify to receive reimbursement for the meals served to your child.

Part 2: List the case number for any household members (including adults) receiving SNAP, Families First Cash Assistance, or Families First Cash Assistance.

If a case number is entered in part 2, skip to part 5. If no case number is provided, proceed to part 3.

Part 3: If any child you are applying for is homeless, migrant, runaway, or participates in Headstart, provide their name(s) and check the appropriate box. Documentation certifying the child's status must be provided with this application.

If you complete Part 3 and have documentation certifying the child's status, skip to part 5.

Part 4:

Column A – Name: List the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you not already listed in part 1. Attach another sheet of paper if you need to.

Column B – Gross Income: For each household member, list each type of income received for the year.
Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Box 1: List the **gross income,** not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.

Box 2: List the amount each person got from the year from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, report income after expenses in Box 1. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: An adult household member must sign and date the form.

The last four digits of the Social Security Number must be provided only if household income information is provided in part 4. If the parent does not have a social security number, check the box for no social security number.

Provide other requested contact information.

Part 6: Answer this question if you choose.

USDA Nondiscrimination 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:

MAIL: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410

FAX: (202) 690-7442; **EMAIL**: program.intake@usda.gov **Only use this address if you are filing a complaint of discrimination**.

This institution is an equal opportunity provider.