C.B.S.
Kosher Food Program
85 Suite F Tomlinson Road ⊙Huntingdon Valley, PA 19006
Phone: 215-938-0201/ FAX: 215-938-0205

CACFP Meal Benefit Income Eligibility Form Instructions

The Child and Adult Care Food Program (CACFP) makes good food a regular part of your child's day care! Please fill out the *CACFP Meal Benefit Income Eligibility* form. It helps us find out if your household qualifies for free or reduced-price meals. This lets us know how much money CACFP will give to support your day care home or center.

Instructions

Here are instructions to help you fill out the form. Before you begin, turn the form over to learn why we ask for this information. It tells you how we use the information and what rights you have. It also tells you how to contact USDA if you believe you are treated unfairly.

Please make sure to fill in all of the requested information. Use a pen to mark your answers on one form. When you are finished, please return the form to us at:

INFO@CBSFOODPROGRAM.COM **or fax 215-938-0205**

C.B.S. Food Program 85 Tomlinson Road Huntingdon Valley, PA 19006, 215-938-0201.

Step 1:

List all the children from your household in the day care. Use one line for each child's name. Write one letter in each box. Stop if you run out of space. If there are more children, add their names on a second piece of paper.

Do you have any foster children? If you answer *Yes*, mark the *Foster Child* box next to the child's name. If you are only applying for foster children, finish Step 1 and go to Step 4. If you are applying for both foster and non-foster children, go to Step 2.

Are any children migrant, runaway, homeless, or enrolled in Head Start? If *Yes*, mark the correct boxes next to the child's name and go to Step 4.

Step 2:

You qualify for free meals if you live in a household that receives Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR).

Do any household members, including you, currently receive SNAP, TANF, or FDPIR? If *Yes*, write the case number in the box and go to Step 4. You only need to provide one case number. If *No*, go to Step 3.

Step 3:

Report current income for all household members. Skip this step if you answered Yes in Step 2.

How do you report child income? Turn the form over and use the *Source of Income for Children* chart to see if your household has income to report. Write the amount in the boxes in part A of the form. Mark how often the amount is earned. Write *0* in the box if there is no income to report.

How do you report income of adult household members? Turn the form over and use the *Source of Income for Adults* chart to see if your household has income to report.

In part B, list all the adults in your household, including you, even if each of you doesn't receive income. Include all adults, such as grandparents, other relatives, and friends who live with you and share household income and expenses. Write the amount of income each of you receives, in the boxes next to your names. Mark how often the amount is received. Write *0* in the box if there is no income to report.

Make sure you report the current amount of money you get before taxes. Don't include SNAP, FDPIR, WIC, student financial aid, or money you receive for a foster child as income.

Count the number of all children and adults in your household. Include all infants, children, students, and adults. Write the total number in the box under the list of adult household members.

Do you or another adult household member have a Social Security number? Write the last four digits in the boxes. If there is no Social Security number, mark the *Check if no SSN* box.

Points to Remember:

If:	Then:
Your income isn't always the same	List the amount of money that you normally get. For example, don't include overtime pay, if you don't normally get it. If your income is normally higher or lower, you can report annual income instead.
Your household includes members who aren't citizens	You or your children don't have to be U.S. citizens to qualify for meal benefits.
You are in the military	Don't include your Family Subsistence Supplemental Allowance (FSSA), combat pay, or the money you receive for privatized housing. If deployed, count the amount of pay that is made available to your household as income.

Step 4:

An adult household member must sign this form. The signer promises that all information is true and complete.

Print the name, address, and telephone or email of the adult signer. Sign and write today's date in the marked boxes.

Optional

We ask about your children's ethnicity and race to make sure we do our best to serve our community. Providing this information is not required. You won't be denied benefits based on your race, color, national origin, sex, age, or disability.

School Year 2019-2020

Dear Parent or Guardian:

CBS offers healthy meals and snacks to children as part of the Child and Adult Care Food Program (CACFP). Your child may be eligible for free or reduced-price meals, depending on your income. Your child qualifies if your household income is less than or equal to the limits on this chart:

Federal Income Standards for Reduced-Price Meals for July 1, 2019 - June 30, 2020		
Household size	Yearly Income	Monthly Income
1	$23,107	$1,926
2	$31,284	42,607
3	$39,461	$3,289
4	$47,638	$3,970
5	$55,815	$4,652

You can find out if your child is eligible by filling out a CACFP Meal Benefit Income Eligibility form. Please be sure to read the instructions carefully. Fill in all the information we request. We can only approve complete forms. Please send the completed form to:

INFO@CBSFOODPROGRAM.COM **or fax 215-938-0205**

C.B.S. Food Program 85 Tomlinson Road Huntingdon Valley, PA 19006, 215-938-0201..

If we approve your form, your child will be eligible for 12 months. We may check the information in the form, at any time during the year, to confirm that your child was eligible when you applied.

If you disagree with our decision, you have the right to appeal it. In the operation of child nutrition programs, no person will be discriminated against because of race, color, national origin, sex, age, or disability. If you have questions or want to request an appeal, please contact **CBS** at **215-938-0201** or **INFO@CBSFOODPROGRAM.COM** .

Thank you for taking the time to apply. We hope your child enjoys CACFP meals!

Sincerely,

Signature

CBS Staff

This institution is an equal opportunity provider.

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 last four digits of 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 or other FDPIR identifier for your child 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 the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

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.

Non-discrimination Statement: **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; or
EMAIL: program.intake@usda.gov.

This institution is an equal opportunity provider.

***Only use this address if you are filing a complaint of discrimination.**

Source of Income for Children

Sources of Child Income	Examples
Earnings from work	A child has a regular full or part-time job where they earn a salary or wages
Social Security - Disability Payments -Survivors Benefits	A child is blind or disabled and receives Social Security benefits A parent is disabled, retired, or deceased, and their child receives Social Security benefits
Income from person outside of household	A friend or extended family member regularly gives a child spending money
Income from any other source	A child receives regular income from a private pension fund, annuity, or trust

Source of Income for Adults

Earnings from Work

-Salary, wages, cash bonuses
-Net income from self-employment (farm or business)

If you are in the U.S. Military:
-Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances)
-Allowances for off-base housing, food, and clothing

Public Assistance/Alimony/ Child Support

-Unemployment benefits
-Workers compensation
-Supplemental Security Income (SSI)
-Cash assistance from State or local government
-Alimony payments
-Child support payments
-Veterans benefits
-Strike benefits

Pensions/Retirement/ All other sources of income

-Social Security (including railroad retirement and black lung benefits)
-Private Pensions or disability benefits
-Income from trusts or estates
-Annuities
-Investment income
-Earned interest
-Rental income
-Regular cash payments from outside household

Child Enrollment Form 2019-2020

Sponsoring Organization: CBS State Sponsored Food Program
Address: 85 Tomlinson Road Suite D
Huntingdon Valley, Pa 19006
Phone: 215-938-0201

Center: SOANS CHRISTIAN ACADEMY 5000006655
Address: 7912 Dungan Rd, Philadelphia, Pennsylvania 19111
Phone: (267) 388-7648

Fill out all FIELDS (*) in PRINT with Black Ink if left blank-forms will NOT be processed-child(ren) will NOT be placed on roster to receive meals

REQUIRED: ➡ *Signature _____ *Date _____
Parent/Guardian

REQUIRED: ➡ *Signature _____ *Date _____
Center Administrator/Home Provider

Normal Hours of Care (write in times)

Monday – Friday Drop Off: _____ Pick Up: _____
* If more than 8 hours of care per day, please attach an explanation to this form.

Saturday Drop Off: _____ Pick Up: _____ Sunday Drop Off: _____ Pick Up: _____

➡* DO NOT LEAVE BLANK! Daily Expected Meal Service Participation (please check box-regardless of age-DO NOT LEAVE BLANK!)

Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐

Is this child of school age? ___Yes ___No If yes, will additional meals be provided by parents when school is not in session? ___Yes ___N If yes, please specify the meal: ___Breakfast ___Lunch ___Snack ___Supper

*Child's FIRST NAME:

*Child's LAST NAME:

*Child's Date of Birth:
*MM / DD / YY

If under 12 months, in addition, need Infant Supplement form (0 to 12 months) 3pages TOTAL

*Address:

*Apt.# or Floor *City *State *Zip Code

*PARENT/GUARDIAN:

(E-mail):

Parental Contacts: This child care facility participates in the Child and Adult Care Food Program. C.B.S. State Sponsored Food Program is the sponsor. In order to receive federal funds, representatives of the sponsoring organization may contact you to verify your child's participation. Please indicate what time and method of contact you prefer:

*Telephone (home): Telephone (work):

___Day ___Evening ___Time
___Letter ___Telephone (home) ___Telephone (work)

"In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. (Not all prohibited bases apply to all programs). To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer."

For Sponsor Use Only

Child enrolled on: _____ Child withdrew on: _____

Child and Adult Care Food Program **Child Care Center Meal Benefit Income Eligibility Form** 2019-2020

Fill out all FIELDS (*) in PRINT with Black Ink if left blank-forms will NOT be processed-child(ren) will NOT be placed on roster to receive meals

Definition of Household Members: "Anyone who is living with you and shares income and expenses, even if not related."

Children in Foster care and children who meet the definition of Homeless, Migrant or Runaway are eligible for free meals. (267) 388-7648

Step 1. All Household Members CHILD'S DAYCARE: SOANS CHRISTIAN ACADEMY 5000006655 7912 Dungan Rd, Philadelphia, Pennsylvania 19111

*Names of **Enrolled** Child(ren) in this daycare: Kids attending THIS location FIRST	LAST	Foster Child	Migrant	Runaway	Homeless	Head Start	*AGE:
		☐	☐	☐	☐	☐	
		☐	☐	☐	☐	☐	
		☐	☐	☐	☐	☐	
		☐	☐	☐	☐	☐	
		☐	☐	☐	☐	☐	
		☐	☐	☐	☐	☐	

***Step 2.** Do any household members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR? YES ☐ NO ☐ (check one)

If NO> Go to Step 3 If YES > Write case number here: * ___ ___ - ___ ___ ___ ___ ___ ___ ___ and proceed to Step 4 (do not complete Step 3)

Step 3: Total Household Gross income and how often it was received e.g. weekly, bi-weekly, twice a month, month

Names of all Household Members (First, Middle Initial, Last) Total # number of people in your house* ☐

Child Income – Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in Step 1 in A 4.
All Adult Household Members (Included yourself) List all Household Members not listed in Step 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

A. Name (List ONLY household members with income)	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income or Child Income	STUDENT-No income
(Example) Jane Smith	$ Gross Income/How often	$ Gross Income/How often	$ Gross Income/How often	$___/___	☐
*	*$ Weekly O Bi-Weekly O Monthly O 2x Month O	$ Weekly O Bi-Weekly O Monthly O 2x Month O	$ Weekly O Bi-Weekly O Monthly O 2x Month O	$	☐
*	*$ Weekly O Bi-Weekly O Monthly O 2x Month O	$ Weekly O Bi-Weekly O Monthly O 2x Month O	$ Weekly O Bi-Weekly O Monthly O 2x Month O	$	☐
*	*$ Weekly O Bi-Weekly O Monthly O 2x Month O	$ Weekly O Bi-Weekly O Monthly O 2x Month O	$ Weekly O Bi-Weekly O Monthly O 2x Month O	$	☐
*	*$ Weekly O Bi-Weekly O Monthly O 2x Month O	$ Weekly O Bi-Weekly O Monthly O 2x Month O	$ Weekly O Bi-Weekly O Monthly O 2x Month O	$	☐
*	*$ Weekly O Bi-Weekly O Monthly O 2x Month O	$ Weekly O Bi-Weekly O Monthly O 2x Month O	$ Weekly O Bi-Weekly O Monthly O 2x Month O	$	☐
*	*$ Weekly O Bi-Weekly O Monthly O 2x Month O	$ Weekly O Bi-Weekly O Monthly O 2x Month O	$ Weekly O Bi-Weekly O Monthly O 2x Month O	$	☐
*	*$ Weekly O Bi-Weekly O Monthly O 2x Month O	$ Weekly O Bi-Weekly O Monthly O 2x Month O	$ Weekly O Bi-Weekly O Monthly O 2x Month O	$	☐

Step 4. Contact information and adult signature. EMAIL COMPLETED FORM TO: INFO@CBSFOODPROGRAM.COM

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

*Signature of Adult Here: ____________ *Print Name of Adult: ____________ *Date: ________

*Address: ____________ *Phone Number: ____________

*City: ____________ *State: ____ *Zip Code: ________

Last four digits of Social Security Number: XXX-XX-* ___ ___ ___ ___ Check if no SSN ☐

Optional. Children's Ethnic and Racial Identities. We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Mark one ethnic identity: ☐ Hispanic or Latino ☐ Hispanic or Latino

Mark one or more racial identities: ☐ Asian ☐ American Indian or Alaska Native ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American

Don't fill out this part. This is for official use only. **C.B.S. USE ONLY!!! DO NOT WRITE BELOW THIS LINE!**

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income ________ How Often? Weekly O Bi-Weekly O Monthly O 2xMonth O Household size: ________ Categorical Eligibility ☐ Eligibility Free O Reduced O Denied O

Determining Official's Signature ________ Date ________ Confirming Official's Signature ________ Date ________ Follow-up Official's Signature ________ Date ________

Code: ____________ ☐ Renewal ☐ Code Change: ________ ☐ Change Daycare: ________

CACFP Meal Benefit Income Eligibility Form

Sharing Information with Medicaid and SCHIP

Children who get Child and Adult Care Food Program (CACFP) free or reduced-price meals may also qualify for low cost health insurance through Medicaid or the State Children's Health Insurance Program (SCHIP).

We may share your child's CACFP eligibility information with Medicaid or SCHIP, *unless you tell us not to.* Medicaid and SCHIP ONLY use the information to find out if children are eligible for their programs. Their staff may contact you to offer to enroll your children in these health insurance programs.

If you **do not** want us to share your information with Medicaid or SCHIP, fill out this page. You should send this page with your *CACFP Meal Benefit Income Eligibility* form when you apply. Sending in this page will not change your child's eligibility for free or reduced-price meals.

☐ **No! I do not** want my child's CACFP eligibility information shared with Medicaid or SCHIP.

If you checked no, fill this out:

Child's Name: _____

Child's Name: _____

Child's Name: _____

Child's Name: _____

Today's Date: _____

Print Your Name: _____

Address: _____

Signature of Parent or Guardian: _____

If you have questions or need help, please contact **CBSStaff** at **215-938-0201** or **INFO@CBSFOODPROGRAM.COM** .

This institution is an equal opportunity provider.

C.B.S.
Kosher Food Program
85 Suite F Tomlinson Road ⊙Huntingdon Valley, PA 19006
Phone: 215-938-0201/ FAX: 215-938-0205

Bringing Education & Nutrition Together

Medical Plan of Care for Child and Adult Care Food Program

(Children with Disabilities and Non-Disabling Special Dietary Needs)

The following child is a participant in the United States Department of Agriculture (USDA) Child and Adult Care Food Program.

- USDA regulations 7CFR Part 15B require substitutions or modifications in program meals for children whose **disability** restricts their diet and is supported by a statement signed by a **licensed physician**. Food allergies which may result in a severe, life-threatening (anaphylactic) reaction may meet the definition of "disability."
- The child care facility may choose to accommodate a child with a **non-disabling special dietary need** that is supported by a statement signed by a **recognized medical authority** (physician, physician assistant or nurse practitioner).

Part 1: To be completed by Parent/Guardian (all requests for special dietary needs)

Fill out all FIELDS (*) in PRINT with Black Ink if left blank-forms will NOT be processed-child(ren) will NOT be placed on roster to receive meals

*Child's Name	*Date of Birth	M F
*Name of School/Center/Program: SOANS CHRISTIAN ACADEMY 5000006655 (267) 388-7648	*Grade Level/Classroom	
*Parent's/Guardian's Name	*Address, City, State, Zip Code	
* Home Phone ( ) -	* Work Phone ( ) -	

***Part 2: To be completed by Physician/Medical Authority** — **Disability/Special Dietary Needs**

*Does the child have a **disability**? Yes ☐ No ☐

If Yes,

Please describe the major life activities affected by the disability.

*Does the child's disability affect their nutritional or feeding needs? Yes ☐ No ☐

*If the child **does not have a disability***, does the child have special nutritional or feeding needs? Yes ☐ No ☐

(*These accommodations are optional for child care facility to make)

If the child has a disability or special dietary/feeding need, please complete Part 3 of this form and have it signed and stamped with the office name and address of a licensed physician/recognized medical authority

***Part 3: To be completed by Physician/Medical Authority**

Diet Order

***List any dietary restrictions, such as food allergies, intolerances or restrictions:**

***List specific foods to be substituted (Substitution cannot be made unless section is completed):**

*List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All".[1]

***Cut up/chopped into bite sized pieces:**

***Finely Ground:**

***Pureed:**

MEDICAL FROM Page 1 of 2

"Bringing Education & Nutrition Together"

C.B.S.

Kosher Food Program

85 Suite F Tomlinson Road ⊙Huntingdon Valley, PA 19006

Phone: 215-938-0201/ FAX: 215-938-0205

Fill out all FIELDS (*) in PRINT with Black Ink if left blank-forms will NOT be processed-child(ren) will NOT be placed on roster to receive meals

*List any special equipment or utensils needed:
*Indicate any other comments about the child's eating or feeding patterns:

*Physician's Name and Office Phone Number	*Office Stamp
*Physician/Medical Authority's Signature	*Date
*Part 4: Parent Signature	*Date
*Part 5: Child Care Facility Signature	*Date

SOANS CHRISTIAN ACADEMY 5000006655 (267) 388-7648

Signing this section is optional, but may prevent delays by allowing us to speak with the physician.

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act, I hereby authorize _____(medical authority) to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to _____(center/facility) and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child with the school program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on _____ (date).

This information is to be released for the specific purpose of Special Diet information.

The undersigned certifies that he/she is the parent, guardian or representative of the person listed on this document and has legal authority to sign on behalf of that person.

*Parent/Guardian Signature:_____ *Date:_____

MEDICAL FROM Page 2 of 2

Please have parent/guardian review form annually and initial/date if no changes are required. Any changes require submission of a new form signed by the Physician/Medical Authority.

*Parent confirmed no change in diet order. Date _____Date_____ _____Date_____ _____Date_____ _____Date_____ _____Date_____