MEAL BENEFIT FORM FOR CHILDREN
PROGRAM YEAR 2017-18

Name of Child Care Center: **Nellie's Wonderland Child Development Center**

Please read the instructions. If you need help completing this form call: **310-671-2099**

Complete, sign, and return form to: **Diane Adams**

1. CHILD INFORMATION
List names of all children enrolled for care

Check the box if the child is a foster child (the legal responsibility of a welfare agency or court).

Last **First** **M.I.**	If all children are foster children, go to number (#) 4 and sign this form**.**
	☐
	☐
	☐
	☐

2. BENEFITS
If you are receiving CalFresh, CalWORKs, or Food Distribution Program on Indian Reservations (FDPIR) benefits for your child, list the case number and **do not** complete #3. Go to #4.

CalFresh Case #:
CalWorks Case #:
FDPIR Case #:

3. ALL HOUSEHOLD MEMBERS
Complete this section if you **did not** complete #2. List all household members including children enrolled for care. List all income. Go to #4.

☐ **Check here if this household receives no income.** Go to #4.

NAMES	**GROSS INCOME** and how often it was received (e.g. weekly, every two weeks, twice a month, monthly, or annually)*			
NAMES OF ALL HOUSEHOLD MEMBERS (INCLUDE THE CHILDREN LISTED ABOVE)	**EARNINGS FROM WORK BEFORE DEDUCTIONS**	**CHILD SUPPORT, ALIMONY**	**PAYMENTS FROM PENSIONS, RETIREMENT, SOCIAL SECURITY**	**EARNINGS FROM ANY OTHER INCOME**
	$	$	$	$
	$	$	$	$
	$	$	$	$
	$	$	$	$
	$	$	$	$
	$	$	$	$

*Applicants without income are requested to write a **zero** in the applicable field or mark **no income**. Any income field left blank is a positive indication of no income and certifies that there is no income to report. Applications with blank income fields will be processed as complete.

4. LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (SSN) AND SIGNATURE

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that the CalFresh, CalWORKS, FDPIR, or other eligible program case number is current, correct, or that all income is reported. I understand that this information is being given for the receipt of federal funds; that agency officials may verify the information on the Meal Benefit Form (MBF) and that the deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.)

Printed Name:	
Last Four Digits of SSN:	☐ Check here if no SSN
Signature of Adult:	Date:

PRIVACY ACT STATEMENT

The Richard B. Russel National School Lunch Act (NSLA) 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 SSN of the adult household member who signs the application. The last four digits of the SSN are not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP, or CalFresh), Temporary Assistance for Needy Families (TANF, or CalWORKS) Program, or 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 SSN. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for the administration and enforcement of the program.

The last four digits of the SSN may be used to identify the household member in verifying the correctness of the information stated on the form. This may include program reviews, audits and investigations, and may include contacting employers to determine income, contacting a CalFresh, CalWORKs, or FDPIR office to determine current certification for CalFresh, CalWORKs, or FDPIR benefits, contacting the state employment security office to determine the amount of benefits received, and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported. The last four digits of the SSN may also be disclosed to programs as authorized under the NSLA and the Child Nutrition Act, the Comptroller General of the United States, and law enforcement officials for the purpose of investigating violations of certain federal, state, and local education, and health and nutrition programs.

5. RACIAL/ETHNIC IDENTITY

You are not required to answer these questions.

If you choose to do so, please mark one or more of the following **racial** identities:		
☐ American Indian or Alaskan Native	☐ Asian	☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander		☐ White
Please mark one of the following **ethnic** identities:		
☐ Hispanic or Latino	☐ Not Hispanic or Latino	

U.S. DEPARTMENT OF AGRICULTURE 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:

(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

(3) E-mail: program.intake@usda.gov

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CATEGORICAL ELIGIBILITY CalFresh/CalWORKS/FDPIR household categorically eligible free? ☐ Yes ☐ No Foster child automatically eligible free? ☐ Yes ☐ No	
INCOME ELIGIBILITY Annual Conversion: Weekly times (x) 52, Every 2 Weeks x 26, Twice a Month x 24, Monthl 12	
Total Income:	Household Size:
Eligibility Classification ☐ Free ☐ Reduced-price ☐ Base	
Determining Official (Print Name):	
Determining Official Signature :	Certification Date:

HOW TO COMPLETE THE MEAL BENEFIT FORM

Using the instructions below, please complete, sign, and return the MBF to: **Diane Adams**
If you need help, call: **310-671-2099**

1. **CHILD INFORMATION:**
   a) Print your child's name. Print your child's name.
   b) Check box to right of name if a foster child.
   c) Include the name of the child care center.

2. **BENEFITS:** Complete this section and sign the form in #4.
   a) List your current CalFresh, CalWORKs, or FDPIR case number(s) for your child(ren).
   b) Sign the form in #4. An adult household member must sign. You do not have to list a SSN.

3. **ALL OTHER HOUSEHOLDS:** Complete this section and sign the form in #4.
   Write the names of everyone in your household even if they do not have an income. Include yourself, your spouse, the child you are applying for, and all other household members. **If your household includes any foster children formally placed by a state child welfare agency or a court, you may choose to include the child(ren) in this list.**
   a) Write the amount of income each person received last month before taxes or anything else was taken out **and** where it came from, such as earnings, pensions, and other income (see examples below for types of income to report). **If you have chosen to include any foster children in your care, only the personal use income is to be listed. Foster payments you receive from the placing agency for the care of the child do not need to be reported.** Each income amount should be entered in the appropriate column on the form. If any amount **last month** was more or less than usual, write that person's usual monthly income.
   b) If anyone is self-employed, write the amount of income that person earns from self-employment. Please call the number listed at the top of the form if you need help.
   c) Sign the form and include the last four digits of your SSN in #4. If you do not have a SSN, check the box "Check here if no SSN."

4. **LAST FOUR DIGITS OF SSN AND SIGNATURE:**
   a) The form must have a **signature** of an adult household member.
   b) The adult household member who signs the statement must include the last four digits of their **SSN**. If they do not have a SSN, check the box "Check here if no SSN". The last four digits of your SSN is not needed if you listed a CalFresh, CalWORKs, or FDPIR case number.

5. **RACIAL/ETHNIC IDENTITY:** You **are not required** to answer this question to get meal benefits, but completion of this information will help ensure that everyone is treated fairly.

INCOME TO REPORT

Earnings from Work:
- Wages/salaries/tips
- Strike benefits
- Unemployment compensation
- Worker's compensation
- Net income from self- employment

Child Support/Alimony
- Public assistance payments
- Alimony/child support payments

Pensions/Retirement/Social Security
- Pensions
- Supplemental security income
- Retirement income
- Veteran's payments
- Social Security

Other Monthly Income
- Disability benefits
- Cash withdrawn from savings
- Interest dividends
- Income from estates/trusts/investments
- Regular contributions from persons not living in the household
- Net royalties/annuities/net rental income
- Military allowance for off-base housing
- Any other income

Nellie's Wonderland Child Development

I wish to enroll my children in the care of the above-named center in order for my children to participate in the Child and Adult Care Food Program (CACFP). I understand that the CACFP reimburses child care centers the serving nutritious and well-balanced meals to children while in care.

Child's Name	Date Enrolled	Age	Birth Date

Hours in our Care
_____AM to _____PM

Check the Meals Your Child(ren) will receive		
Breakfast	Lunch	Snack

Check Usual Days of Care

Child's Name_____

Monday	Tuesday	Wednesday	Thursday	Friday

Check Usual Days of Care

Child's Name_____

Monday	Tuesday	Wednesday	Thursday	Friday

Signature of Parent/Guardian: _____ Date: _____

Address: _____

Home Telephone Number: _____