

## Letter to Parents (Nonpricing Program)

Dear Parent/Guardian:

The \_\_\_\_\_ child care center participates in the Child and Adult Care Food Program (CACFP) offered by the U.S. Department of Agriculture (USDA) and serves meals at no separate charge to all enrolled children. The reimbursement received from the CACFP helps with our food costs, and therefore, enables us to keep our fees for care as low as possible.

Please help us comply with the requirements of the USDA CACFP. Please complete, sign, and return the attached meal benefit form (MBF) to the center as soon as possible. However, you are not required to submit the MBF to participate in the program. All children enrolled in our center receive their meals at no separate charge, but the determination of eligibility category affects the amount of funding received by our center. This information is necessary to receive the reimbursement for the meals we serve to children in our program. If your first language is not English, you have a right to ask us for written or oral translation of these materials free of charge in your native language.

If your household currently receives benefits under the CalFresh Program (formerly Food Stamps), the California Work Opportunity and Responsibility for Kids (CalWORKs), or the Food Distribution Program on Indian Reservations (FDPIR), you only need to list your current CalFresh, CalWORKs, or FDPIR case number on the MBF. You must also have an adult sign and date the MBF.

However, if your household does not receive benefits under CalFresh, CalWORKs, or FDPIR, please complete the MBF and make sure you:

- Provide the names of all household members and their income by source; and
- Have an adult sign, date, and provide the last four digits of their Social Security number (SSN) or check the box Check here if no SSN (only if the adult does not have an SSN).

### For All Households

The USDA defines a household as a group of related or unrelated individuals (not residents of a boarding house or an institution) who are living as one economic unit (i.e., sharing living expenses). Therefore, the income reported on the MBF must include the gross income of all members of your household by source.

The income you report must be the total gross income received last month, listed by source for each household member. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last year's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income Eligibility Guideline chart, the center receives a higher level of reimbursement for meals served to your child(ren).

Once properly approved for free or reduced-price benefits, whether through income or proof of benefits as supported by a current CalFresh, CalWORKs, or FDPIR case number, your child(ren) will remain eligible for those benefits for 12 months.

## **Foster Children**

For households with foster children, please contact us for additional information.

## **Confidentiality of Information on the Meal Benefit Form**

We will use the information on the form to decide the level of reimbursement our center is eligible to receive. We will place the MBF in our food program files and keep the information confidential. Only upon your request will we share the information on your form with officials of other child nutrition, health, and education programs so they can use it to determine benefits for those programs.

Thank you for your cooperation. If you have any questions or need assistance in filling out the MBF, please contact:

**Center Representative:**

**Phone Number:**

### Income Eligibility Scale

Effective from July 1, 2023, through June 30, 2024.

#### Centers Reduced-price and Day Care Home Tier I Scale

Household size	Annual	Monthly	Twice per month	Every two weeks	Weekly
1	\$26,973	\$2,248	\$1,124	\$1,038	\$519
2	\$36,482	\$3,041	\$1,521	\$1,404	\$702
3	\$45,991	\$3,833	\$1,917	\$1,769	\$885
4	\$55,500	\$4,625	\$2,313	\$2,135	\$1,068
5	\$65,009	\$5,418	\$2,709	\$2,501	\$1,251
6	\$74,518	\$6,210	\$3,105	\$2,867	\$1,434
7	\$84,027	\$7,003	\$3,502	\$3,232	\$1,616
8	\$93,536	\$7,795	\$3,898	\$3,598	\$1,799
For each additional family member, add	\$9,509	\$793	\$397	\$366	\$183

The term household means a group of related or unrelated individuals who are not residents of an institution or boarding house but who are living as one economic unit, sharing housing and all significant income and expenses.

**This scale does not apply to households that receive CalFresh, CalWORKs, or FDPIR. Those children are automatically eligible for free meal benefits.**

## **U.S. Department of Agriculture (USDA) Nondiscrimination Statement**

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](mailto:program.intake@usda.gov)

**This institution is an equal opportunity provider.**

## Meal Benefit Form for Children Program Year

Name of Child Care Center:

Please read the instructions. If you need help completing this form, please call:

Complete, sign, and return this form to:

### 1. Child Information

List names of all children enrolled for care.

Last Name	First Name	Middle Initial	Foster Child?

If all children listed are foster children, skip to Section 4.

### 2. Benefits

If you are receiving CalFresh, California Work Opportunity and Responsibility to Kids (CalWORKs), or Food Distribution Program on Indian Reservations (FDPIR) benefits for your child, list the case number and **do not complete Section 3**. Skip to Section 4.

CalFresh Case Number:

CalWORKs Case Number:

FDPIR Case Number:

### 3. All Other Households

Complete this section if you did not complete Section 2. List all household members including children enrolled for care. List total household gross income and how often it is received (e.g., weekly, every two weeks, twice a month, monthly, or annually).

Check here if this household receives no income. Skip to Section 4.

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.

Names of all household members, including child(ren) listed above	Earnings from work before deductions	Child support, alimony	Payments from pensions, retirement, Social Security	Earnings from any other income
<i>Example: Janet Smith</i>	<i>\$200/weekly</i>	<i>\$150/twice a month</i>	<i>\$100/monthly</i>	<i>\$0</i>

**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 Parent or Guardian:

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 an 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

If you choose to do so, please mark one of the following ethnic identities:

Hispanic or Latino

Not Hispanic or Latino

**For Agency Use Only**

**Categorical Eligibility:**

CalFresh/CalWORKS/FDPIR household categorically eligible?      Yes      No  
Foster child automatically eligible free?      Yes      No

**Income Eligibility:**

Annual Conversion (required if household reports various pay frequencies in Section 3):  
Weekly times (x) 52, every 2 weeks x 26, twice a month x 24, monthly x 12

Total Household Income and Frequency:                      per

Household Size:

**Eligibility Classification:**

Eligibility Classification:      Free      Reduced-price      Base

Determining Official Name:

Determining Official Signature:

Date:



## How to Complete the Meal Benefit Form

### 1. Child Information

- a. Print your child's name.
- b. Indicate **yes** to the right of a child's name if they are a foster child.

### 2. Benefits: If you receive any benefits listed in this section, complete this section, and then skip to Section 4 and sign the form.

- a. List your current CalFresh, CalWORKs, or FDPIR case number(s) for your child(ren).
- b. Sign the form in Section 4. An adult household member must sign. You do not have to list an SSN.

### 3. All Other Households: Complete this section only if you do not have a case number for the benefits listed in Section 2.

- a. Complete this section and sign the form in Section 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.
- b. 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.
- c. 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.
- d. Sign the form and include the last four digits of your SSN in Section 4. If you do not have an SSN, place a checkmark next to **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 an SSN, they will place a checkmark next to the No SSN line.
- c. The last four digits of the adult household member's SSN is not needed if a CalFresh, CalWORKs, or FDPIR case number is provided.

- 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, or tips
- Strike benefits
- Unemployment compensation
- Worker's compensation
- Net income from self-employment

### **Child Support or Alimony**

- Public assistance payments
- Alimony or child support payments

### **Pensions, Retirement, or 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, or investments
- Regular contributions from persons not living in the household
- Net royalties, annuities, or net rental income
- Military allowance for off-base housing
- Any other income

## Description of Racial and Ethnic Categories

The federal government has established the following five racial categories and two ethnic categories:

### Race:

**American Indian or Alaska Native**—A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

**Asian**—A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, The Philippine Islands, Thailand, and Vietnam.

**Black or African American**—A person having origins in any of the black racial groups of Africa.

**Native Hawaiian or Other Pacific Islander**—A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

**White**—A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

### Ethnicity:

**Hispanic or Latino**—A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin" can be used in addition to "Hispanic or Latino."

**Not Hispanic or Latino**

## **U.S. Department of Agriculture (USDA) Nondiscrimination Statement**

In accordance with federal civil rights law and USDA civil rights regulations and policies, the USDA, its agencies, offices, 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, audiotope, 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 <https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint> 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. Email: [program.intake@usda.gov](mailto:program.intake@usda.gov)

**This institution is an equal opportunity provider.**

Korean American Family Services  
 Child Care Food Program  
 3727 W. 6<sup>th</sup> Street Suite 320, Los Angeles, CA 90020

**CHILD ENROLLMENT APPLICATION**

New \_\_\_\_\_ Renew \_\_\_\_\_

Center Name: <b>Golden City Child Development Center</b>	Center Address: <b>812 E. Carson St. Carson CA 90745</b>
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**FATHER/MOTHER/GUARDIAN READ AND COMPLETE**

**STATEMENT OF UNDERSTANDING:** My child(ren) is enrolled in the care of the above provider and I understand that by completing this application that my child(ren) will participate in the Child Care Food Program (CCFP). I understand that the CCFP reimburses child care providers for serving nutritious, well-balanced meals to children while in day care.

I understand that my child(ren) will receive meals when they are in attendance during any of the scheduled meal services. I understand that these meals will be provided at no extra charge to me, nor will I be required to bring food items to supplement the Child Care Food Program.

**INSTRUCTIONS TO PARENT/GUARDIAN:**

Complete all of the information on this form in ink. Sign this form as an acknowledgement that you have authorized your child to participate and return it to the child care facility.

Name of Child First name/Last name	1 <sup>st</sup> Day of Care	Age	Birth date	Sex	Non-School Days Hours in Care		Vacation/Holiday Hours in Care	
					In	Out	In	Out
	/ /		/ /	M / F				

**DAYS OF USUAL CARE:** Monday  Tuesday  Wednesday  Thursday  Friday  Saturday \_\_\_\_\_ Sunday \_\_\_\_\_

**MEALS TO BE SERVED:** Breakfast \_\_\_\_\_ AM Snack  Lunch  PM Snack \_\_\_\_\_ Dinner

<b>Parent Name:</b>	
<b>Address:</b>	<b>City: ZIP:</b>
<b>Phone:</b>	Work Phone:
Emergency Contact Other Than Parent/Provider:	Phone:
<b>SIGNATURE OF PARENT/GUARDIAN:</b>	Date:

Physician's Name:	Phone:
Child Food allergies:	
<b>Doctor's note required for Milk or grains / Handicap required Doctor's note or IEP</b>	

**RACIAL-ETHNIC HERITAGE OF YOUR CHILD(REN):** Although you are not required to provide this information, your cooperation will help determine compliance with federal civil rights laws. If you decline to provide this information, it will in no way affect your child's participation in the CCFP. Collection of this information is in accordance with Title VI of the Civil Rights Act of 1964 and us strictly for statistical reporting requirements. If willing, please circle the correct category:

Am. Indian/Alaskan Native    Asian/Pacific Islander    Black-Not Hispanic Origin    Hispanic    White-Not Hispanic Origin

NON DISCRIMINATION – The Child Care Food Program is available to everyone regardless of race, color, national origin, age, sex, religion, or disability. If you believe that you or your child has been discriminated against in any USDA-related activity, you should write immediately to: Administrator, Food and Nutrition Service, 3101 Park Center Drive, Alexandria, VA 22302

For Sponsor Use Only (If applicable)	
Eligibility Category: Base _____	Recertification Date: _____ Base:
Sponsor Representative Signature:	Date: