

Child and Adult Care Food Program (CACFP) Formula/Food Sign-Off Statement



As a participant in the CACFP, we must offer to supply all infant meal food components, as developmentally appropriate, to all infants in our care.

We will supply the following items to your infant:

- Iron-fortified infant formula
- Iron-fortified infant cereal
- Infant foods and/or table foods in the appropriate texture for the age of your infant.

Parents/Guardians may choose to accept our supplied infant formula and/or foods or provide their own. Mothers are always welcome to breast feed on-site and/or provide expressed breastmilk.

Parents/Guardians may provide one food component towards a reimbursable meal. Our center must supply all other meal components, as developmentally ready, to receive reimbursement.

Please check your preferences below for each meal pattern requirement.

Our center will supply the following formula and infant food:

Formula offered by our center: Infamil, Similac
(Specific brand/type identified by center)

Parent/Guardian check your breast milk/formula preference:

- | | |
|---|--|
| <input type="checkbox"/> I want the center to provide formula to my infant | <input type="checkbox"/> I will bring iron-fortified formula for my infant |
| <input type="checkbox"/> I will come to the center to breast feed my infant | <input type="checkbox"/> I will bring expressed breast milk for my infant |

Iron-Fortified Infant Cereal offered by our center:

- ☒ Rice ☒ Barley ☒ Wheat ☒ Oat ☒ Multi-grain

Parent/Guardian check your infant cereal preference:

- ☐ I want the center to provide iron fortified infant cereal for my infant
- ☐ I will bring iron fortified infant cereal for my infant

Food offered by our center:

- ☒ Store-bought infant foods
- ☒ Table foods at the appropriate consistency for the development of your infant

Parent/Guardian check your infant food preference:

- ☐ I want the center to provide developmentally appropriate foods for my infant
- ☐ I will bring foods for my infant

If parent/guardian is supplying any breast milk, formula, or infant foods: Specify what we may feed our infant if they are still hungry after they are fed what has been supplied for the day:

Infant Name: _____ Birth Date: _____

Parent/Guardian Signature: _____ Date Signed: _____

Non-Discrimination Statement

In accordance with Federal law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on basis of race, color, national origin, sex, age, disability, and reprisal or retaliation for prior civil rights activity. (Not all prohibited bases apply to all programs.) 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 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. Additionally, program information is available in languages other than English.

If you have a complaint alleging discrimination, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at www.ascr.usda.gov/complaint_filing_cust.html, or 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: usda.intake@usda.gov. This institution is an equal opportunity provider.

If any member of your household receives FAP, FIP, or FDIPIR, provide the name and case number for the person who receives the benefits.

Name:

Case Number:

[illegible]

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 receive federal funds if I am approved for services. I understand that if I purposely give false information, I may be prosecuted.

Print Name: _____

For Institution Use Only:

_____ I do not have a Social Security Number

<p>Total Household Members:</p>		<p>Total Income: \$</p>		<p>_____ Annually</p> <p>_____ Monthly</p> <p>_____ 2x Month</p>	<p>_____ Bi-Weekly</p> <p>_____ Weekly</p>
<p>Institution Official Signature: _____</p>			<p>Approval Date: _____</p>		
<p>APPROVED CATEGORY</p> <p>Categorical Eligibility (A/Free): Foster FIP FAP FDP/IR</p> <p>Other Household Children: A (Free) B (Reduced) C (Paid)</p>			<p>_____</p>		

Return this completed form to: Cradle 2 Cradle

Participant Enrollment Form

Instructions:

1. List full name of participant enrolled in care
2. Circle the typical days each participant is in care
3. List times each participant is in care
4. Circle the meals and snacks each participant typically receives while in care
5. Select the ethnicity of each participant using the following codes: H = Hispanic or Latino, N = Not Hispanic or Latino* Native, A = Asian, B = Black or African American, H/PI = Native Hawaiian or Pacific Islander, W = White*
6. Select one or more racial designations of each participant using the following codes: H = Hispanic or Latino, N = Not Hispanic or Latino* Native, A = Asian, B = Black or African American, H/PI = Native Hawaiian or Pacific Islander, W = White*
7. Sign and date the form and return to your care center

Participant's First and Last Name	Typical Days in Care (circle all that apply)	List Times in Care	Meals/Snacks Received (circle all that apply)	Ethnicity	Race
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		

* This information is voluntary. This will assist us in assuring the Child and Adult Care Food Program is administered in a nondiscriminatory manner.

Adult/Parent/Guardian's Address

Signature of Adult/Parent/Guardian

Adult/Parent/Guardian's Phone Number

Date Signed

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, audiotape, 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> 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: **mail:** U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; or **fax:** (833) 256-1665 or (202) 690-7442; or **email:** program.intake@usda.gov. This institution is an equal opportunity provider.

USDA Civil Rights Complaint Link:

<https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>