

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: City 619-388-3205 Mesa 619-388-2812 Miramar 619-388-7851

INCOME ELIGIBILITY GUIDELINES												
Effective from July 1, 2023 to June 30, 2024												
HOUSEHOLD SIZE	FEDERAL POVERTY GUIDELINES		REDUCED PRICE MEALS - 185 %					FREE MEALS - 130 %				
	ANNUAL		MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY	ANNUAL	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY	
48 CONTIGUOUS STATES, DISTRICT OF COLUMBIA, GUAM, AND TERRITORIES												
1	14,580		26,973	2,248	1,124	1,038	519	18,954	1,580	790	729	365
2	19,720		36,482	3,041	1,521	1,404	702	25,636	2,137	1,069	986	493
3	24,860		45,991	3,833	1,917	1,769	885	32,318	2,694	1,347	1,243	622
4	30,000		55,500	4,625	2,313	2,135	1,068	39,000	3,250	1,625	1,500	750
5	35,140		65,009	5,418	2,709	2,501	1,251	45,682	3,807	1,904	1,757	879
6	40,280		74,518	6,210	3,105	2,867	1,434	52,364	4,364	2,182	2,014	1,007
7	45,420		84,027	7,003	3,502	3,232	1,616	59,046	4,921	2,461	2,271	1,136
8	50,560		93,536	7,795	3,898	3,598	1,799	65,728	5,478	2,739	2,528	1,264
For each add'l family member, add	5,140		9,509	793	397	366	183	6,682	557	279	257	129
ALASKA												
1	18,210		33,689	2,808	1,404	1,296	648	23,673	1,973	987	911	456
2	24,640		45,584	3,799	1,900	1,754	877	32,032	2,670	1,335	1,232	616
3	31,070		57,480	4,790	2,395	2,211	1,106	40,391	3,366	1,683	1,554	777
4	37,500		69,375	5,782	2,891	2,669	1,335	48,750	4,063	2,032	1,875	938
5	43,930		81,271	6,773	3,387	3,126	1,563	57,109	4,760	2,380	2,197	1,099
6	50,360		93,166	7,764	3,882	3,584	1,792	65,468	5,456	2,728	2,518	1,259
7	56,790		105,062	8,756	4,378	4,041	2,021	73,827	6,153	3,077	2,840	1,420
8	63,220		116,957	9,747	4,874	4,499	2,250	82,186	6,849	3,425	3,161	1,581
For each add'l family member, add	6,430		11,896	992	496	458	229	8,359	697	349	322	161
HAWAII												
1	16,770		31,025	2,586	1,293	1,194	597	21,801	1,817	909	839	420
2	22,680		41,958	3,497	1,749	1,614	807	29,484	2,457	1,229	1,134	567
3	28,590		52,892	4,408	2,204	2,035	1,018	37,167	3,098	1,549	1,430	715
4	34,500		63,825	5,319	2,660	2,455	1,228	44,850	3,738	1,869	1,725	863
5	40,410		74,759	6,230	3,115	2,876	1,438	52,533	4,378	2,189	2,021	1,011
6	46,320		85,692	7,141	3,571	3,296	1,648	60,216	5,018	2,509	2,316	1,158
7	52,230		96,626	8,053	4,027	3,717	1,859	67,899	5,659	2,830	2,612	1,306
8	58,140		107,559	8,964	4,482	4,137	2,069	75,582	6,299	3,150	2,907	1,454
For each add'l family member, add	5,910		10,934	912	456	421	211	7,683	641	321	296	148

MEAL BENEFIT FORM (MBF) FOR CHILDREN
PROGRAM YEAR 2023-24 (Attach Agreement for Enrollment)

Name of Child Care Center: Child Development Center / Early Education at: ☐ City ☐ Mesa ☐ Miramar

Please read the instructions. If you need help completing this form, call: (619) 388-

Complete, sign, and return form to: Center Office

1. CHILD INFORMATION

List names of all children enrolled for care.

Child FIRST Name	Child LAST Name	Middle Initial	✓ if Foster Child*
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

* If all children listed are foster children, skip Sections 2 & 3, and go 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. Go to Section 4.

Program	Case Number**
CalFresh	
CalWORKs	
FDPIR	

** If you provided a Case Number, skip Section 3 and go to Section 4

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** and skip to Section 4.

Names of ALL household members, including child(ren) listed above	Earnings from <u>work</u> 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 month</i>	<i>\$100/monthly</i>	<i>\$0</i>
1.				
2.				
3.				
4.				
5.				
6.				
7.				

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	✓ if No SSN
		<input type="checkbox"/>
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 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

FOR AGENCY USE ONLY

Categorical Eligibility:

- a. CalFresh / CalWORKS / FDPIR household categorically eligible? ☐ Yes ☐ No
 b. Foster child automatically eligible? ☐ 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: ☐ Free ☐ Reduced-Price ☐ Base

Determining Official Name _____

Determining Official Signature _____ Date _____ Initial of 2nd official _____

1. CHILD INFORMATION:

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

2. BENEFITS: Complete this section, 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.

- 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. **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

- 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 his or her 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.

- a. **DESCRIPTION OF RACIAL AND ETHNIC CATEGORIES:** The federal government has established the following five racial categories and two ethnic categories:
 - i. **RACE:** American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White
 - ii. **ETHNICITY:** 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, 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](http://www.ascr.usda.gov/complaint_filing_cust.html), (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. Email: program.intake@usda.gov

This institution is an equal opportunity provider.