

Ohio Child and Adult Care Food Program
ANNUAL RENEWAL OR (PARENT/PROVIDER MOVE) CHILD ENROLLMENT FORM ~FAMILY DAY CARE HOME
 Please review before sending to 4C.

DEAR PARENT OR GUARDIAN: PROVIDER NAME _____ ID #: _____ Phone: _____

By signing this form, you agree your child is enrolled in the Child and Adult Care Food Program for reimbursed meals and the information below is for our use in contacting you about meals served to your child(ren) and their welfare.

The CACFP is a child nutrition program of the US Department of Agriculture (USDA). Its purpose is to help day care providers with the cost of nutritious, well-balanced meals for day care children. A provider may claim payment for up to 2 meals and one snack or 2 snacks and one meal per child per day. You should not be asked to bring extra food or charged for your children's meals. Your provider must keep a daily record of menus and the number of children served meals. Menus and attendance records should be posted for you to see. WE MAY CALL OR WRITE YOU to find out if you are satisfied with the meals. What you tell us will be confidential. Please call our office if you have questions.

IS YOUR CHILD CARED FOR BY ANY OTHER PROVIDER? **Yes** **No** If yes list provider's name(s): _____

ID #s	Children's NAMES (and nicknames)	Birth date	Sex		Related to provider		CHILD TYPE				Circle REGULAR days provider has child	Enter HOURS with provider (include am & pm)		Circle All meals regularly eaten WITH PROVIDER	Circle meals eaten at SCHOOL & kindergarten	
			M	F	Yes	No	County Foster	Private Own/Res	C	P		F	O			Arrive
											M T W R F S U			B am L pm S ev	brkf lunch	
											M T W R F S U			B am L pm S ev	brkf lunch	
											M T W R F S U			B am L pm S ev	brkf lunch	
											M T W R F S U			B am L pm S ev	brkf lunch	
COMPLETE this section if children are with provider for occasional days including HOLIDAYS											CIRCLE OCCASIONAL DAYS		CIRCLE OCCASIONAL MEALS			
REASON for occasional care:											M T W R F S U HOLIDAYS		B am L pm S ev			

Please Print Name _____ **Signature of parent or guardian** _____ **Date** _____ **Home Telephone** _____ **Daytime/Work Telephone** _____

Street Address/Apartment Number _____ **City** _____ **Zip Code** _____ **County** _____ **Email address** _____

VOLUNTARY RACIAL ETHNIC DATA: Please check the ethnic group which best describes your child(ren). *This information is collected to ensure all children have equal access to meals. Your answer will be kept confidential.* The CACFP is available to all eligible children without regard to race, color, national origin, gender, age or disability. To file a discrimination complaint, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Bldg, 1400 Independence Avenue, SW, Washington DC, 20250-9410 or call (202)720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

Racial identity: American Indian or Alaskan Native Asian Black or African American Native Hawaiian or other Pacific Islander White
 Ethnic identity: Hispanic or Latino

For Contact: _____ **Agency Name: 4C** _____ **Annetta Rutland (513)221-** _____
 _____ **0033** _____