

NEW APPLICANT TRAINING

Maine

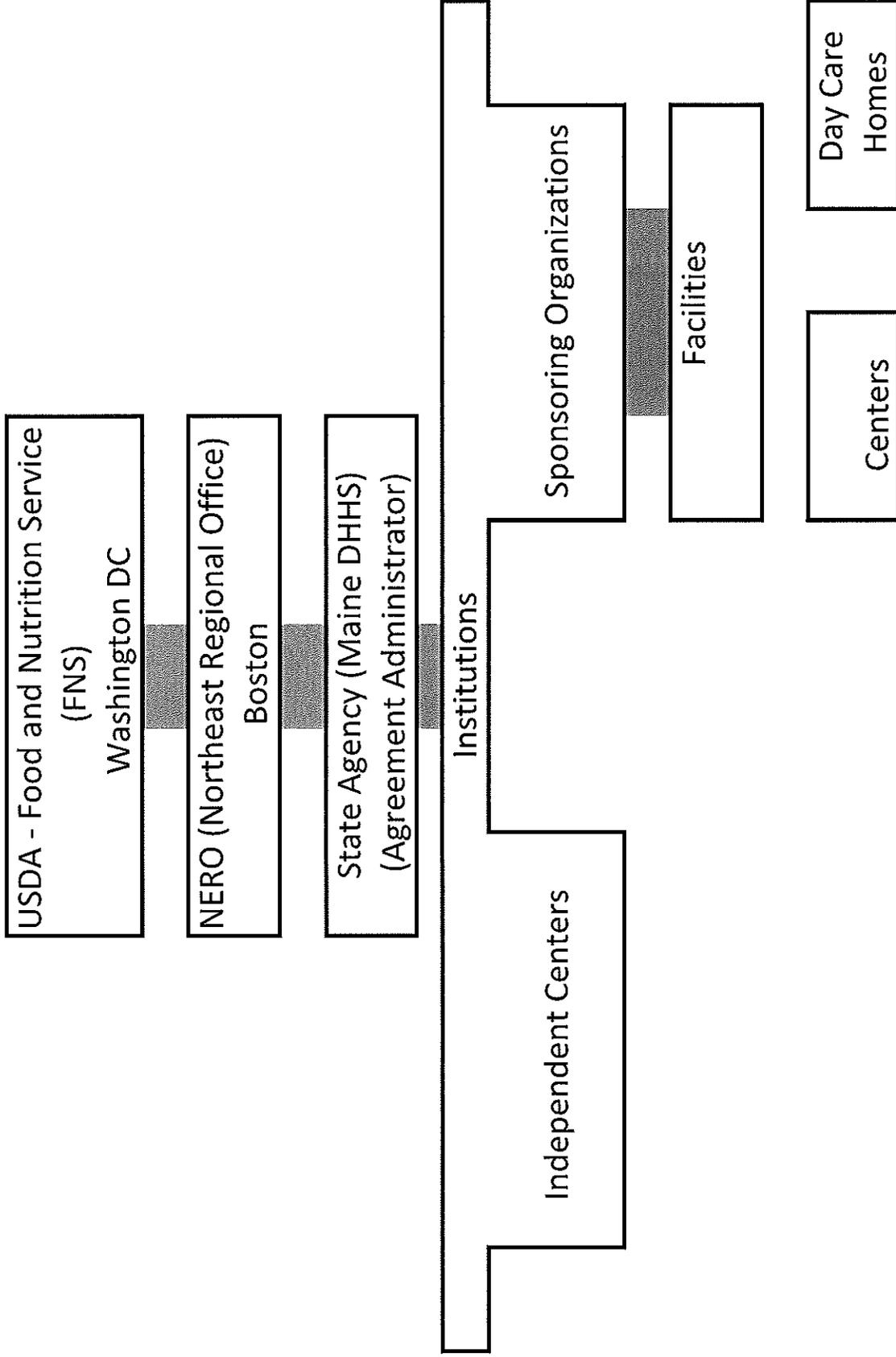


CACFP

Child and Adult Care Food Program

MAINE DHHS, OFFICE OF CHILD AND FAMILY SERVICES

CACFP ORGANIZATIONAL STRUCTURE



Child and Adult Care Food Program

Memorandum

To: ALL CACFP PARTICIPANTS

From: CACFP Staff

Subject: REPORTABLE CHANGES

CACFP# 01-03

In order to streamline current procedures regarding your CACFP contract, please be advised that you are no longer required to report routine changes for the following to your Agreement Administrator:

- Mealtime changes*
- Meals to be claimed*
- Updates to License Certification numbers or effective date changes*
- Telephone numbers*

***PLEASE NOTE THIS INFORMATION MUST STILL BE INCLUDED IN THE INITIAL CACFP CONTRACT THAT IS RENEWED ANNUALLY. Institutions are also responsible to record the above information/changes and keep it on file so that it is available for review during an unannounced visit or Supervisory Review.**

If a center or provider license is outdated, it is the institutions responsibility to get proof that the license update is in process before allowing a claim to be made for meals. This may include a copy of the license fee payment, a letter from licensing or a copy of the licensing list.

Changes that must still be reported to the Agreement Administrator:

- Name changes
- Address changes
- Tier changes
- License capacity changes
- Changes regarding the claiming of a provider's own children and children enrolled in excess of licensed capacity

- Change of staff involved in the CACFP, i.e., director, CACFP managers, financial staff, etc. (non-profits may need Board approval)
- Budgetary changes
- Enrollment numbers
- Additions and Deletions for a Sponsored Center or Provider

Meal Counts, menus and infant menus, and production reports (if applicable) must be kept on file at CACFP Participant sites and are not sent to the State office unless requested.

Daily menus and production report components should agree and any changes to them should be made at the beginning of the day.

FDCH providers must have all original records (meal counts, enrollments, menus) on site or in their possession for 3 years.

Please refer to the most recent Crediting Food Guide or Food Buying Guide for Child Nutrition Programs (CACFP web site) if you have questions regarding reimbursable versus non-reimbursable food/beverage items. If the food/beverage is listed in the Buying Guide, it is reimbursable; if it is not, it is not reimbursable.

Please contact your CACFP Agreement Administrator if you have any questions regarding the aforementioned changes.



STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
11 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0011

Paul R. LePage
Governor

For Use in **CHILD CARE CENTERS**
July 1, 2015 to June 30, 2016

Dear Parent:

The Child Care Center in which you are enrolling your child participates in the U.S. Department of Agriculture's Child and Adult Care Food Program. This means the Center must serve meals and supplements that meet or exceed the nutritional requirements set forth by the U.S. Government.

In return for serving meals and supplements that meet these requirements, the Center receives payment from the USDA based on the income levels of the families being served. The higher the number of children served by the Center who come from low income households, the higher is the level of reimbursement received by the Center for the meals and supplements it serves.

In order to determine the level of reimbursement to be received by the Center for meals or supplements served to your child, USDA requests you to complete the attached application and to include all of the following information on the appropriate lines.

1. The name and age of the child for whom you are making application.
2. If the child for whom you are making application, or any other person in your household, is a member of a Supplemental Nutrition Assistance Program (SNAP) Household (formerly known as Food Stamps), Temporary Assistance to Needy Families (TANF) Assistance Unit or a household that receives benefits under the Food Distribution Program on Indian Reservations (FDPIR), you may give their SNAP, TANF or FDPIR case number in PART I and then skip to PART III.
3. IN PART II you must include the name of each person living in the "household". A "household" is any group of persons living together sharing income and living expenses. These persons may or may not all be related to each other.
4. The last four (4) digits of the Social Security number of the household member or guardian who signs the application form.
5. The total income, before deductions, from all sources, for all persons living in the household.
6. The signature, address, and telephone number of the person completing the application form. The date the form was signed must also be included.

By regulation, if any of the above required information is not included on the application form, the Center has to consider your child to be in that category of eligibility which qualifies it to receive the lowest level of payment for the meals and supplements your child will receive.

The following chart shows the upper income level for the 'Tier I' category for the period **July 1, 2015 to June 30, 2016**. If the total income for your household size is equal to or less than the amount shown, the center serving your child will be able to receive the Tier I, or highest, level of reimbursement for meals or supplements served to your child.

Eligibility Scale for "Reduced-Price" Meals

Family Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	21,775	1,815	908	838	419
2	29,471	2,456	1,228	1,134	567
3	37,167	3,098	1,549	1,430	715
4	44,863	3,739	1,870	1,726	863
5	52,559	4,380	2,190	2,022	1,011
6	60,255	5,022	2,511	2,318	1,159
7	67,951	5,663	2,832	2,614	1,307
8	75,647	6,304	3,152	2,910	1,455
Each Additional Family Member	7,696	642	321	296	148

If a member of your household becomes unemployed, your child may become eligible for "Free" or "Reduced-Price" meals during the period of unemployment, provided the loss of income causes the household income to fall within the eligibility guidelines for your household size.

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.

To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (866) 632-9992 (voice) or (800) 877-8339 (TTY) or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

Thank you.

Sincerely,

Staff:
 Child and Adult Care Food Program
 Office of Child and Family Services

**APPLICATION FOR "FREE" OR "REDUCED-PRICE" MEALS
CHILD AND ADULT CARE FOOD PROGRAM (CACFP)**

CHILD FOR WHOM APPLICATION IS BEING MADE: Name: _____ Age: _____

Days of the Week in Care	Hours in Care (i.e. 7:30 – 5:00)	Meals Received While in Care*						
<input type="checkbox"/> Monday		<input type="checkbox"/> Br	<input type="checkbox"/> AM S	<input type="checkbox"/> Lu	<input type="checkbox"/> PM S	<input type="checkbox"/> Su	<input type="checkbox"/> E S	
<input type="checkbox"/> Tuesday		<input type="checkbox"/> Br	<input type="checkbox"/> AM S	<input type="checkbox"/> Lu	<input type="checkbox"/> PM S	<input type="checkbox"/> Su	<input type="checkbox"/> E S	
<input type="checkbox"/> Wednesday		<input type="checkbox"/> Br	<input type="checkbox"/> AM S	<input type="checkbox"/> Lu	<input type="checkbox"/> PM S	<input type="checkbox"/> Su	<input type="checkbox"/> E S	
<input type="checkbox"/> Thursday		<input type="checkbox"/> Br	<input type="checkbox"/> AM S	<input type="checkbox"/> Lu	<input type="checkbox"/> PM S	<input type="checkbox"/> Su	<input type="checkbox"/> E S	
<input type="checkbox"/> Friday		<input type="checkbox"/> Br	<input type="checkbox"/> AM S	<input type="checkbox"/> Lu	<input type="checkbox"/> PM S	<input type="checkbox"/> Su	<input type="checkbox"/> E S	
<input type="checkbox"/> Saturday		<input type="checkbox"/> Br	<input type="checkbox"/> AM S	<input type="checkbox"/> Lu	<input type="checkbox"/> PM S	<input type="checkbox"/> Su	<input type="checkbox"/> E S	
<input type="checkbox"/> Sunday		<input type="checkbox"/> Br	<input type="checkbox"/> AM S	<input type="checkbox"/> Lu	<input type="checkbox"/> PM S	<input type="checkbox"/> Su	<input type="checkbox"/> E S	

* Br = Breakfast AM S = AM Snack Lu = Lunch PM S = PM Snack Su = Supper E S = Evening Snack

NOTE: If you are applying for CACFP benefits on behalf of a Foster Child, please check this box and notify the person to whom you return this form. Foster Child

PART I: HOUSEHOLDS RECEIVING SNAP, TANF OR FDPIR BENEFITS:

If you, your child, or any other person living in your household, currently receives SNAP, TANF or FDPIR benefits, please provide their SNAP, TANF or FDPIR case number. **DO NOT COMPLETE Part II; skip to Part III.** Part III must include the **printed name and signature of the adult who completes this application.** The **date the application was completed** needs to be included also.

(a) YES: A member of this household receives SNAP, TANF or FDPIR benefits.

(b) SNAP Case Number: # _____ (**not** EBT number)

(c) TANF Case Number: # _____

(d) FDPIR Case Number: # _____

If applicable, your child's Free or Reduced-Price meal eligibility information will be disclosed to Medicaid and/or SCHIP unless you elect not to have the information disclosed. The information will be used to identify children eligible for, and to seek to enroll children in, a health insurance program. Your decision on whether to disclose this information will not affect your child's eligibility for Free or Reduced-Price meals.

If you elect not to have this information disclosed to Medicaid and/or SCHIP, please check this box:

NOTE #1:

If no one in your household receives SNAP, TANF or FDPIR benefits, or if you do not provide their case number, you must complete Part II and Part III in order for your child to qualify for either "Free" or "Reduced-Price" meals. **You must also include the last four (4) digits of your Social Security Number on the line next to your signature.**

PART II: ALL OTHER HOUSEHOLDS:

(a) **Household Members:** List the name of every person living in your household. **Be sure to include yourself and the child listed above.**

(b) **Social Security Number:** Section 9 of the National School Lunch Act requires that, unless a SNAP or TANF case number is provided for your child, you must include the last four (4) digits of your Social Security number on the application. This must be the Social Security number of the adult household member signing the application. If the adult household member signing the application does not possess a Social Security number, he/she must indicate so on the application. Provision of a Social Security number is not mandatory, but if the last four (4) digits of the adult household member's Social Security number is not provided or an indication is not made that the adult household member signing the application does not have one, the application cannot be approved. This notice must be brought to the attention of the household member whose Social Security number is disclosed. The Social Security number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the application. These verification efforts may be carried out through program reviews, audits and investigations and may include contacting employers to determine income, contacting a SNAP, Indian Tribal Organization or Welfare Office to determine current certification for receipt of SNAP, FDPIR or TANF benefits, contacting the State Employment Security Office to determine the amount of benefits received and checking the documentation produced by household members to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal action if incorrect information is reported.

(C) **Income:** List all income from all sources received last month on the same line as the name of the person who received it. Income must be gross; that is, it must be the amount received before deductions for taxes, Social Security, dues, insurance, etc. List each amount under the correct column. *If you are in the Military Privatized Housing Initiative or receive combat pay, please do not include these allowances as income.*

LIST ALL HOUSEHOLD MEMBERS:

Names of Household Members:	Age	Monthly Gross Wages or Net Self-Employment	Monthly TANF, Alimony, Welfare, Child Support	Monthly Pensions, SSI, Social Security, Workers Comp, Unemployment Comp, Insurance & Retirement
1.				
2.				
3.				
4.				
5.				
6.				
(Note: Weekly income x 4.333 weeks; Bi-weekly income x 2.15 weeks)				
TOTAL MONTHLY HOUSEHOLD INCOME:				

PART III:

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.

To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (866) 632-9992 (voice) or (800) 877-8339 (TTY) or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that all income is reported. I understand this information is being given in connection with the receipt of Federal Funds and Program Officials may verify the information on the application and that deliberate misrepresentation of any of the information on this application may subject me to prosecution under applicable State and Federal Criminal Statutes.

(PRINT NAME OF ADULT)	(LAST 4 DIGITS OF SS#)	(SIGNATURE OF ADULT)	(DATE)
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(HOUSEHOLD ADDRESS OF ADULT)	(HOME PHONE)	(WORK PHONE)
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ALL HOUSEHOLDS: Racial/Ethnic Identity:*

1. Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino

2. Race (mark one or more):

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

*This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws. Your response will not affect consideration of your application. If you decline to self-identify your child's race and ethnicity, a visual identification will be made and recorded.

THIS PORTION MUST BE COMPLETED BY CHILD CARE CENTER PERSONNEL:

Signature: _____ Date: _____

Child's Eligibility Category (Circle One): Free Reduced-Price Paid



Paul R. LePage
Governor

STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
11 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0011

For Use in Adult Day Care Centers

July 1, 2015 - June 30, 2016

Dear Household Member:

The Adult Day Care Center in which you are enrolling participates in the Child and Adult Care Food Program (CACFP) under the direction of the U.S. Department of Agriculture (USDA). This means the Center must serve meals and snacks that meet or exceed the nutritional requirements set forth by the U.S. Government.

In return for serving meals and supplements that meet these requirements, the Center receives payment from the USDA based on the income levels of the individuals or households it serves. The higher the number of adults served who are low income, or who come from low income households, the more the Center receives as payment for the meals and supplements it serves.

In order that the Center may comply with the requirements of the CACFP, please complete, sign, date, and return the attached enrollment form as soon as possible. This form must be placed in the Center's files and treated as confidential information.

In order to qualify the Center to receive either the "Free" or the "Reduced-Price" rate of reimbursement for the meals and supplements you receive, the enrollment form must be completed as follows:

Supplemental Nutrition Assistance Program (SNAP)/SSI/MEDICAID HOUSEHOLDS: If the person being enrolled currently receives SNAP (formerly known as Food Stamps), Supplemental Security Income (SSI), or Medicaid assistance, list that person's name, SNAP, SSI, or Medicaid case identification number, and sign and date the application. Since income information has already been given to the officials responsible for these programs, the enrollees' eligibility can be confirmed.

ALL OTHER HOUSEHOLDS: If the gross income of the household in which the enrollee lives falls at or below the current eligibility guidelines for the number of persons in the household, the Center will qualify to receive either "Free" or "Reduced-Price" reimbursements for meals served to the enrollee. In order to make this determination, the following information must be included on the form:

- Household Members: List the names of the enrollee, his or her spouse, and/or any other individual(s) who reside with the enrollee and depend on the enrollee for economic support. These individuals make up a "household" for the purposes of the Child and Adult Care Food Program.
- Monthly Income: List the total monthly income (BEFORE deductions for taxes, social security, etc.) received by each household member during the most recent month. Also, list the sources of this income such as wages, self employment, retirement, or welfare assistance. If any household member's income was higher or lower than usual, show that person's average monthly income.

--Signature: An adult member of the household must sign and date the application.

If a working member of the household becomes unemployed, and if this loss of income causes the total household income to fall within the CACFP eligibility guidelines, the enrollee may qualify the Center for "Free" or "Reduced-Price" reimbursements during this period of unemployment.

The following chart shows the income levels to be used for the **July 1, 2015- June 30, 2016** period to determine what amount of payment it will be able to receive for the meals and snacks served to you.

Eligibility Scale For "Reduced-Price" Meals

Family Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	21,775	1,815	908	838	419
2	29,471	2,456	1,228	1,134	567
3	37,167	3,098	1,549	1,430	715
4	44,863	3,739	1,870	1,726	863
5	52,559	4,380	2,190	2,022	1,011
6	60,255	5,022	2,511	2,318	1,159
7	67,951	5,663	2,832	2,614	1,307
8	75,647	6,304	3,152	2,910	1,455
Each Additional Family Member	7,696	642	321	296	148

Thank you for your time and cooperation in completing the enclosed forms. All participants in the Adult Day Care portion of the CACFP must complete one of these applications, even if they are in the "Paid" category, as the CACFP regulations require everyone in the Center to be so enrolled. At least the enrolled person's name, age, and the last four (4) digits of their social security number must be entered, and an adult must sign and date the application.

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.

To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (866) 632-9992 (voice) or (800) 877-8339 (TTY) or (800)845-6136 (Spanish). USDA is an equal opportunity provider and employer.

Thank you.

Sincerely,

Child and Adult Care Food Program
Office of Child & Family Services

CHILD AND ADULT CARE FOOD PROGRAM
ADULT DAY CARE

This Adult Day Care Center is a participant in the Child & Adult Care Food Program (CACFP), a Federal program of the Food and Nutrition Service (FNS), U.S. Department of Agriculture (USDA).

In accordance with Federal law and U. S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.

To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (866) 632-9992 (voice) or (800) 877-8339 (TTY) or (800)845-6136 (Spanish). USDA is an equal opportunity provider and employer.

The primary goal of the Child & Adult Care Food Program is to improve the diet of adults enrolled in Adult Day Care Centers.

Nutrition is an important part of good health. Proper nutrition is also an important part of a good Adult Day Care Food Program. Adults need well-balanced meals in order to meet their daily energy needs and to help them maintain strong bodies and minds. Through the CACFP you can be assured that you are getting balanced, nutritious meals. As participants in the CACFP, adult day care organizations may serve up to three meals a day to each adult. If three meals are served, at least one of them must be a snack. All of the meals must follow patterns set by USDA.

The meal pattern set by USDA is as follows:

Breakfast	Lunch or Supper	Snack
Milk Juice, fruit or vegetable Bread or bread alternate	Milk Meat or meat alternate Vegetables and/or fruits Bread or bread alternate	(Serve two of the following four foods. Juice may not be served when milk is served as the only other food.) Milk Meat or meat alternate Fruit, vegetable, or juice Bread or bread alternate

An Adult Day Care Center is any public agency or nonprofit organization or any proprietary Title XIX or Title XX center which is licensed or approved by Federal, State or local authorities to provide nonresidential adult day care services to functionally impaired adults or persons sixty years of age or older in a group setting outside their homes on a less than 24-hour basis. The regulation further specifies that adult day care centers provide a community based program designed to meet the needs of functionally impaired adults through an individual plan of care. This program must be a structured comprehensive program that provides a variety of health, social and related support services to enrolled adult participants.

CHILD AND ADULT CARE FOOD PROGRAM
APPLICATION FOR MEALS IN ADULT DAY CARE CENTERS

To apply for free and reduced price meals in an Adult Day Care Center, carefully complete this form, sign it and return it to the center. If you need help with this form, please call the center.

PART 1: COMPLETE THIS PART ONLY IF THE INDIVIDUAL TO BE ENROLLED IN THE CENTER IS CURRENTLY A MEMBER OF A SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) HOUSEHOLD OR RECEIVES ASSISTANCE THROUGH THE SUPPLEMENTAL SECURITY INCOME (SSI) PROGRAM OR THROUGH MEDICAID. IF THIS PART IS COMPLETED, SKIP PART 2, GO TO PART 3.

Enrollee's Name: _____ Age: _____ (Check all that apply) Case Number: _____
Medicaid: SSI: SNAP:

PART 2: COMPLETE THIS PART ONLY IF PART 1 IS NOT APPLICABLE. (If more space is needed, please use a separate sheet of paper.)

Enrollee's Name: _____ Age: _____

Under "NAME" you must list the name of the enrollee and of his/her spouse and/or any other individuals who reside with the enrollee and who depend on the enrollee for economic support. In the appropriate column, list ALL income received last month on the same line as the name of the person who received it. The GROSS income amount must be listed (the amount BEFORE deductions for taxes, Social Security, etc.). Please list the total income received for the month in appropriate space at the bottom.

NAME: (Last, First)	Age:	Salary-Wages Before Deductions:	Welfare, Child Support & Alimony	All Other Income:
1.				
2.				
3.				
4.				
5.				
(Note: Weekly Income x 4.333 weeks; Bi-weekly Income x 2.15 weeks)				
TOTAL MONTHLY HOUSEHOLD INCOME:				

PART 3: IDENTIFYING INFORMATION AND CERTIFICATION OF DATA:

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given in relation to the receipt of Federal funds; that the information on the application may be verified; and that the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

SIGNATURE: An adult **MUST** sign the application before it can be approved and the last four (4) digits of the social security number of the person signing the application **must** be provided*.

(PRINT NAME OF ADULT)	(*LAST 4 DIGITS OF SS#)	(SIGNATURE OF ADULT)	(DATE)
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(HOUSEHOLD ADDRESS OF ADULT)	(HOME PHONE)	(WORK PHONE)
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ALL HOUSEHOLDS: Racial/Ethnic Identity:**

The spouse/guardian is not required to answer this question, but the information **is requested** to ensure that everyone receives benefits on a fair basis.

1. Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino

2. Race (mark one or more):

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

****This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws. Your response will not affect consideration of your application. If you decline to self-identify the enrollee's race and ethnicity, a visual identification will be made and recorded.**

*Section 9 of the National School Lunch Act requires that, unless a SNAP or TANF case number is provided, you must include the last four (4) digits of a Social Security number on the application. This must be the last four (4) digits of the Social Security number of the adult household member signing the application. If the adult household member signing the application does not possess a Social Security number, he/she must indicate so on the application. Provision of a Social Security number is not mandatory but if the last four (4) digits of a Social Security number are not provided or an indication is not made that the adult household member signing the application does not have one, the application cannot be approved. This notice must be brought to the attention of the household member whose Social Security number is disclosed. The Social Security number may be used to identify the household member in carrying out efforts to verify the accuracy of information stated on the application. These verification efforts may be carried out through program reviews, audits and investigations and may include contacting employers to determine income, contacting a SNAP, Indian Tribal Organization or Welfare Office to determine current certification for receipt of SNAP, FDPIR or TANF benefits, contacting the State Employment Security Office to determine the amount of benefits received and checking the documentation produced by household members to verify the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal action if incorrect information is reported.

THIS PORTION MUST BE COMPLETED BY THE CENTER'S INTAKE PERSONNEL:

Enrollee's Eligibility Category (circle one): **Free** **Reduced-Price** **Paid**

Signature

Date

Child and Adult Care Food Program



FOOD CHART



Ages:	1-2	3-5	6-12
Breakfast			
1 Fluid Milk	½ cup	¾ cup	1 cup
1 Vegetable/Fruit	¼ cup	½ cup	½ cup
1 Grain/Bread			
• Bread	½ slice	½ slice	1 slice
• Biscuit/Roll/Muffin/Cornbread	½ serving	½ serving	1 serving
• Cold Dry Cereal	¼ cup	1/3 cup	¾ cup
• Hot Cooked Cereal	¼ cup	¼ cup	½ cup
Lunch/Supper			
1 Fluid Milk	½ cup	¾ cup	1 cup
2 Vegetable/Fruit (2 different types)	¼ cup	½ cup	¾ cup
1 Grain/Bread			
• Bread	½ slice	½ slice	1 slice
• Biscuit/Roll/Muffin/Cornbread	½ serving	½ serving	1 serving
• Pasta/Noodles/Grains	¼ cup	¼ cup	½ cup
1 Meat/Meat Alternate			
• Meat/Poultry/Fish	1 oz.	1 ½ oz.	2 oz.
• Cheese	1 oz.	1 ½ oz.	2 oz.
• Egg	½	¾	1
• Cooked Dry Beans or Peas	¼ cup	3/8 cup	½ cup
• Peanut Butter or Nut/Seed Butters	2 Tbsp.	3 Tbsp.	4 Tbsp.
• Nuts and Seeds	½ oz.	¾ oz.	1 oz.
• Yogurts	4 oz.	6 oz.	8 oz.
• Alternate Protein Product	1 oz.	1 ½ oz.	2 oz.
Snack (Select at least two different components from the following four**)			
1 Fluid Milk	½ cup	½ cup	1 cup
1 Vegetable/Fruit	½ cup	½ cup	¾ cup
1 Grain/Bread	½ slice or serving	½ slice or serving	1 slice or serving
1 Meat/Meat Alternate			
• Cheese	½ oz.	½ oz.	1 oz.
• Egg	½	½	½
• Peanut Butter or Nut/Seed Butters	1 Tbsp.	1 Tbsp.	2 Tbsp.
• Nuts and Seeds	½ oz.	½ oz.	1 oz.
• Yogurts	2 oz.	2 oz.	4 oz.

Child and Adult Care Food Program



FOOD CHART



ADULT CARE MEAL PATTERN

Breakfast (All 3 Components)

1 Fluid Milk	1 cup
1 Vegetable/Fruit	½ cup
1 Grain/Bread	
• Bread	2 slices
• Biscuit/Roll/Muffin/Cornbread	2 servings
• Cold Dry Cereal	1 ½ cups
• Hot Cooked Cereal	1 cup

Lunch (All 4 Components)

1 Fluid Milk	1 cup
2 Vegetable/Fruit (2 different types)	1 cup
1 Grain/Bread	
• Bread	2 slices
• Biscuit/Roll/Muffin/Cornbread	2 servings
• Pasta/Noodles/Grains	1 cup
1 Meat/Meat Alternate	
• Meat/Poultry/Fish	2 oz.
• Cheese	2 oz.
• Egg	1
• Cooked Dry Beans or Peas	½ cup
• Peanut Butter or Nut/Seed Butters	4 Tbsp.
• Nuts and Seeds	1 oz.
• Yogurts	8 oz.
• Alternate Protein Product	2 oz.

Supper (All 3 Components)

2 Vegetable/Fruit (2 different types)	1 cup
1 Grain/Bread	
• Bread	2 slices
• Biscuit/Roll/Muffin/Cornbread	2 servings
• Pasta/Noodles/Grains	1 cup
1 Meat/Meat Alternate	
• Meat/Poultry/Fish	2 oz.
• Cheese	2 oz.
• Egg	1
• Cooked Dry Beans or Peas	½ cup
• Peanut Butter or Nut/Seed Butters	4 Tbsp.
• Nuts and Seeds	1 oz.
• Yogurts	8 oz.
• Alternate Protein Product	2 oz.

Snack (Select at least two different components from the following four)

1 Fluid Milk	1 cup
1 Vegetable/Fruit	½ cup
1 Grain/Bread	1 slice or serving
1 Meat/Meat Alternate	
• Meat or Cheese	1 oz.
• Egg	½
• Peanut Butter or Nut/Seed Butters	2 Tbsp.
• Nuts and Seeds	1 oz.
• Yogurts	4 oz.

Dietary Restrictions & Substitutions Statement

The following statement is for United States Department of Agriculture (USDA) programs,
including the **Child and Adult Care Food Program**.

USDA regulations 7CFR Part 15B requires substitution or modifications in school/program meals for children whose disabilities (defined below) restrict their diets. A child with a disability must be supplied substitutions in foods when that need is supported by a statement signed by a licensed physician. Food allergies which may result in severe, life-threatening (anaphylactic) reaction, also meet the definition of "disability", and the substitutions prescribed by the licensed physician/medical authority would be made.

- **"Disability"**: A physical or mental impairment which substantially limits one or more of an individual's major life activities.
- **"Major Life Activity"**, as defined by ADA: caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, and major bodily functions.
- **"Major Bodily Functions"** has been defined as: functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, and reproductive functions.

The statement must include the following:

To be completed by Parent/Guardian

Child's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Address: _____

Phone Number: (Home) _____ (Work) _____

Parent/Guardian Signature: _____ Date: _____

To be completed by child's Physician or Medical Authority:

State the "disability" and major life activities affected:

List the food allergies or food intolerances:

List the food or beverages to be substituted:

List any additional dietary restrictions or special diet:

Physician's Name: _____ Office Number: _____

Physician/Medical Authority Signature: _____ Date: _____

*Please have parent/guardian review form annually and initial/date if no changes are required.

*Any changes require submission of a new form signed by the child's physician or medical authority.

CACFP Weekly Menu (5-Day)

Sponsor / Site Name: _____ Month / Year _____

Type	Component	Minimum Serving	Date:				
			Monday	Tuesday	Wednesday	Thursday	Friday
Breakfast	Milk, fluid	1 cup	20				
	Juice, fruit or vegetable	½ cup	bananas				
	Bread/roll/muffin Etc. Cold dry cereal Cooked cereal Pasta/noodles/grain	2 servings 1 ½ cups 1 cup 1 cup	corn flakes oatmeal muffins				
	Other extra food items						

To be reimbursable, each snack must contain one food item from TWO of the four food groups. Two fluids do not constitute a creditable snack (milk and juice).

Type	Component	Minimum Serving	Date:				
			Monday	Tuesday	Wednesday	Thursday	Friday
AM Snack (select 2)**	Milk, fluid	1 cup					
	Juice, fruit or vegetable	½ cup					
	Bread/roll/muffin Etc. Cold dry cereal Cooked cereal Pasta/noodles/grain	1 serving ¾ cup ½ cup ½ cup					
	Meat / meat alternate Egg Beans/peas Yogurt Nut/seed butter	1 ounce ½ egg ¼ cup 4 ounces 2 Tbsp.					
Other extra food items							
Lunch	Milk, fluid	1 cup					
	Meat / meat alternate Egg Beans/peas Yogurt Nut/seed butter	2 ounces 1 egg ½ cup 8 ounces 4 Tbsp.					
	Bread/roll/muffin Etc. Cold dry cereal Cooked cereal Pasta/noodles/grain	2 servings 1 ½ cups 1 cup 1 cup					
	Fruit and/or vegetable and/or juice (2 or more) Other extra food items	1/2 cup 1/2 cup					

CACFP Child Meal Pattern Reminders

- Fluid Milk
 - Serve whole milk to children between 1-2 years of age
 - Serve fat-free (skim) or low-fat (1%) milk to children 2 years and older
- Meat / alternate portion is for the served edible portion (for example, bones don't count towards the portion size).
- Snacks:
 - Select 2 different components for a reimbursable meal.
 - Juice cannot be served when milk is the only other component served

Lunch / Supper

- Serve 2 or more types of fruit and/or vegetables.
 - 100% vegetable or fruit juice cannot count for more than 1 of the 2 servings.
- If seeds or nuts are served as the meat/alternate, they can only "count" as 50% of the portion size.
 - Seeds or nuts must be combined with another meat/alternate to fulfill the portion size requirements.

If meals are being served to adult caregivers to provide a role model for children, the 3 to 5 year old serving size should be used when calculating the additional amount of food to purchase for the adults. These meals and snacks are not reimbursable.

At-Risk After School Meal Program Children 13 thru 18 years of age

- Children are eligible to participate in the At-Risk After School Meal Program thru age 18.
- Children ages 13 thru 18 must be served at least the minimum (or larger size) portions served to children in the 6 thru 12 age category.

CACFP Weekly Menu (5-Day)

Sponsor / Site Name:		Month / Year					
Type	Component	Minimum Serving	Minimum Serving	Minimum Serving	Date:	Date:	Date:
		1 and 2 years (A)	3 - 5 years (B)	6 - 12 years (C)	Monday	Tuesday	Wednesday
						Thursday	Friday
Breakfast	Milk, fluid	1/2 cup	3/4 cup	1 cup			
	Juice, fruit or vegetable	1/4 cup	1/2 cup	3/4 cup			
	Grains/Breads	1/2 slice	1/2 slice	1 slice			
	Cold dry cereal	1/4 cup (or 1/3 oz)	1/3 cup (or 1/2 oz)	3/4 cup (or 1 oz)			
	Cooked cereal	1/4 cup	1/4 cup	1/2 cup			
	Other extra food items						
To be reimbursable, each snack must contain one food item from TWO of the four food groups. Two fluids do not constitute a creditable snack (milk and juice).							
AM Snack (select 2)**	Milk, fluid	1/2 cup	1/2 cup	1 cup			
	Juice, fruit or vegetable	1/2 cup	1/2 cup	3/4 cup			
	Grains/Breads	1/2 slice*	1/2 slice*	1 slice*			
	Cold dry cereal	1/4 cup (or 1/3 oz)	1/3 cup (or 1/2 oz)	3/4 cup (or 1 oz)			
	Meat or meat alternate	1/2 oz.	1/2 oz.	1 oz.			
	Other extra food items						
Lunch	Milk, fluid	1/2 cup	3/4 cup	1 cup			
	Meat or meat alternate	1 oz.	1 1/2 oz.	2 oz.			
	Grains/Breads	1/2 slice*	1/2 slice*	1 slice*			
	Pasta/Noodles	1/4 cup	1/4 cup	1/2 cup			
	Fruit and/or vegetable and/or juice (2 or more)	1/4 cup total	1/2 cup total	3/4 cup total			
	Other extra food items						

To be reimbursable, each snack must contain one food item from TWO of the four food groups. Two fluids do not constitute a creditable snack (milk and juice).						
PM Snack (select 2)**	Milk, fluid	1/2 cup	1/2 cup	1 cup		
	Juice, fruit or vegetable	1/2 cup	1/2 cup	3/4 cup		
	Grains/Breads Cold dry cereal	1/2 slice* 1/4 cup (or 1/3 oz).	1/2 slice* 1/3 cup (or 1/2 oz)	1 slice* 3/4 cup (or 1 oz)		
	Meat or meat alternate	1/2 oz.	1/2 oz.	1 oz.		
	Other extra food items					
Supper						
Supper	Milk, fluid	1/2 cup	3/4 cup	1 cup		
	Meat or meat alternate	1 oz.	1 1/2 oz.	2 oz.		
	Grains/Breads Pasta/Noodles	1/2 slice* 1/4 cup	1/2 slice* 1/4 cup	1 slice* 1/2 cup		
	Fruit and/or vegetable and/or juice (2 or more)	1/4 cup total	1/2 cup total	3/4 cup total		
	Other extra food items					

To be reimbursable, each snack must contain one food item from TWO of the four food groups. Two fluids do not constitute a creditable snack (milk and juice).						
Evening Snack (select 2)**	Milk, fluid	1/2 cup	1/2 cup	1 cup		
	Juice, fruit or vegetable	1/2 cup	1/2 cup	3/4 cup		
	Grains/Breads Cold dry cereal	1/2 slice* 1/4 cup (or 1/3 oz).	1/2 slice* 1/3 cup (or 1/2 oz)	1 slice* 3/4 cup (or 1 oz)		
	Meat or meat alternate	1/2 oz.	1/2 oz.	1 oz.		
	Other extra food items					

For more information, please refer to CACFP Child Care Meal Pattern Chart. This is an equal opportunity provider and employer.
 Include caregiver's meals in column B

CACFP Meal Pattern Reminders

- Fluid Milk
 - Serve fat-free (skim) or low-fat (1%) milk.
 - Milk is not required at Supper.

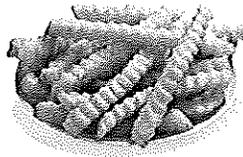
- Meat / alternate portion is for the served edible portion (for example, bones don't count towards the portion size).

- Snacks:
 - Select 2 different components for a reimbursable meal.
 - Juice cannot be served when milk is the only other component served.

Lunch / Supper

- Serve 2 or more types of fruit and/or vegetables.
 - 100% vegetable or fruit juice cannot count for more than 1 of the 2 servings.
- If seeds or nuts are served as the meat/alternate, they can only "count" as 50% of the portion size.
 - Seeds or nuts must be combined with another meat/alternate to fulfill the portion size requirements.
- Offer versus Serve allows adults to refuse 1 component at Breakfast, 2 components at Lunch and 2 components at Supper.

ACTIVITY: USING THE FOOD BUYING GUIDE TO CALCULATE AMOUNT OF FOOD NEEDED



You are planning to serve $\frac{1}{2}$ cup servings of baked French fries.

You estimate that you will need 45 servings.

Using the Food Buying Guide, calculate how much you will need to purchase.

1. Locate the item in the *Food Buying Guide*.
2. Look in column 4 to check the serving size listed. If it does not match your serving size, you need to convert it.
Serving size in column 4: _____
3. How many of the serving size that you wrote above will you need to get your 45 serving of $\frac{1}{2}$ cup each?

Total servings needed (of amount that was listed in column 4): _____

4. Now look at column 2 and find the purchase unit: _____
and look at column 3 for the number of serving that you will get out of each purchase unit: _____
5. Divide the total number of servings needed (from #3) by the number of servings that you get in a purchase unit (from column 3):

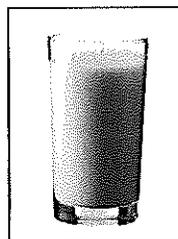
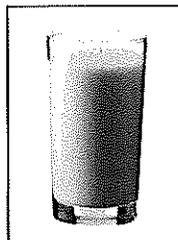
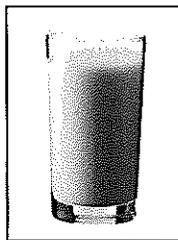
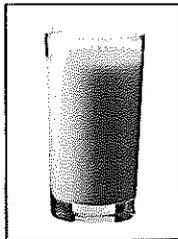
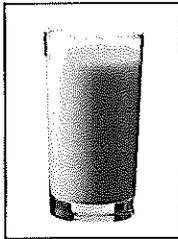
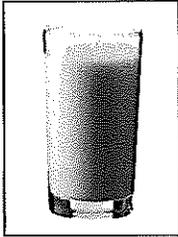
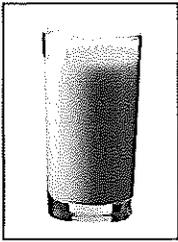
Round up to ensure that enough food is available.

Answer: _____ of fries will be needed to have 45 servings of $\frac{1}{2}$ cup each.

Section 2—Vegetables/Fruits

1 Food As Purchased, AP	2 Purchase Unit	3 Servings per Purchase Unit, EP	4 Serving Size per Meal Contribution	5 Purchase Units for 100 Servings	6 Additional Information
POTATOES (continued)					
Potatoes, frozen Shells	Pound	11.1	1/4 cup baked vegetable	9.1	1 lb AP = 0.90 lb baked potato shell
Potatoes, frozen Wedges <i>USDA Commodity</i>	Pound	11.9	1/4 cup baked vegetable	8.5	1 lb AP = 0.71 lb (about 2-7/8 cups) baked potato
	5 lb pkg	59.5	1/4 cup baked vegetable	1.7	5 lb bag = about 14-7/8 cups baked potato
Potatoes, frozen Whole Small	Pound	10.1	1/4 cup cooked vegetable	10.0	
Potatoes, dehydrated Diced <i>Low moisture Includes USDA Commodity</i>	Pound	45.1	1/4 cup reconstituted, heated vegetable	2.3	1 lb dry = about 5-1/8 cups dehydrated diced potatoes
Potatoes, dehydrated Flake <i>Low moisture Includes USDA Commodity</i>	Pound	50.5	1/4 cup reconstituted, heated vegetable	2.0	1 lb dry = about 7-1/2 cups dehydrated potato flakes
Potatoes, dehydrated, Granules <i>Low moisture Includes USDA Commodity</i>	Pound	50.5	1/4 cup reconstituted, heated vegetable	2.0	1 lb dry = about 2-1/4 cups dehydrated potato granules
Potatoes, dehydrated Slices <i>Low moisture Includes USDA Commodity</i>	Pound	43.5	1/4 cup reconstituted, heated vegetable	2.3	1 lb dry = about 9-2/3 cups dehydrated potato slices
POTATOES, FRENCH FRIES					
Potatoes, French Fries, frozen Crinkle cut <i>Low moisture Ovenable Includes USDA Commodity</i>	Pound	16.2	1/4 cup cooked vegetable	6.2	1 lb AP = 0.92 lb (about 4 cups) baked French fries
	4 lb pkg	64.9	1/4 cup cooked vegetable	1.6	

CACFP MILK REQUIREMENTS



FAT-FREE AND LOW-FAT MILK: Milk served in the CACFP must be consistent with the most recent version of the Dietary Guidelines for Americans. The 2010 Dietary Guidelines recommend that persons over two years of age consume low-fat (1%) or fat-free (skim) fluid milk. Therefore, fluid milk served in CACFP to participants two years of age and older must be: fat-free or low-fat milk, fat-free or low-fat lactose reduced milk, fat-free or low-fat lactose free milk, fat-free or low-fat buttermilk, or fat-free or low-fat acidified milk. Milk served must be pasteurized fluid milk that meets State and local standards, and may be flavored or unflavored. **Whole milk and reduced-fat (2%) milk may not be served to participants over two years of age. If served, the meal is not reimbursable and will be disallowed.**

WHOLE MILK: It is recommended, but not required, that children 12 through 23 months of age be served whole milk only.

Can a participant or parent/guardian request that they be served whole or reduced fat (2%) milk? No. It is required that milk served to participants in the CACFP be aligned with the most recent Dietary Guidelines for Americans. The 2010 Dietary Guideline for Americans recommends that persons over the age of two, consume low-fat (1%) or fat-free (skim) milk. Therefore, any request for higher fat milk must be made through a medical statement, related to a medical disability and prescribed by a licensed physician.

NON-DAIRY BEVERAGES:

What if a participant is not able to consume fluid milk due to a MEDICAL or OTHER SPECIAL DIETARY NEED (documentation required from doctor), other than a disability? Non-dairy beverages may be served in lieu of fluid milk. Non-dairy beverages must be nutritionally equivalent to milk and meet the nutritional standards for fortification of calcium, protein, vitamin A, vitamin D, and other nutrients to levels found in cow's milk. (Call your sponsor for specific details on nutrition requirements) **If this substitution is provided by the daycare provider or the parent/guardian, it is reimbursable.**

What if a parent/guardian requests in writing a non-dairy milk

MILK SUBSTITUTES...MINIMUM NUTRITIONAL REQUIREMENTS

NUTRIENT	UNIT	VALUE PER CUP (244g)
Protein	g	8
Calcium, Ca	mg	276
Magnesium, Mg	mg	24
Phosphorus, P	mg	222
Potassium, K	mg	349
Riboflavin	mg	0.44
Vitamin B-12	µg	1.10
Vitamin A	IU	500
Vitamin D	IU	100

Based upon USDA required nutrients - fortified to the levels found in whole milk

Fat Free = Skim Milk

Low Fat = 1% Milk Fat

Reduced Fat = 2% Milk Fat

Full Fat = Whole Milk

USDA Approved Fluid Milk Substitutes

MILK PROTEIN ALLERGY	LACTOSE INTOLERANCE
8 th Continental Original Soy Milk (1)	Lactaid (lactose free) Milk
Pacific Natural Soy Milk (2)	Low Fat Lactose Reduced Milk
Pacific Natural Vanilla Soy Milk (3)	
Pearl Organic Smart Vanilla Soy Milk (4)	
Pearl Organic Smart Chocolate Soy Milk (5)	

(1) Hannaford, Shaw's, Target (2) Hannaford, Shaw's (3) Hannaford, Shaw's (4) Sam's, Wal-Mart (5) Sam's, Wal-Mart

Parents or guardians may now request in writing non-dairy milk substitutions, as described above, without providing a medical statement. As an example, if a parent has a child who follows a vegan diet, the parent can submit a written request to the child's caretaker asking that soy milk be served in lieu of cow's milk. The written request must identify the medical or other special dietary need that restricts the diet of the child.

It is at the caregiver's discretion to provide a non-dairy substitute if it is not related to a medical disability.

All non-dairy milk substitutes are at the expense of the caregiver and/or the child's parent or guardian.

If a parent provides a non-dairy milk substitute that meets the nutritional standards as outlined in 7 CFR 210.10 (m)(3) and that has been approved by the State agency, the caregiver may serve the non-dairy milk substitute and still claim reimbursement for the meal.

CACFP RATES FOR JULY 1, 2015 ~ JUNE 30, 2016

Per meal rates in Whole or Fractions of US Dollars

Rates	Breakfast	Lunch & Supper	Snack
Free	1.66	3.07	0.84
Reduced	1.36	2.67	0.42
Paid	0.29	0.29	0.07

CIL: 23.75 cents

Tier 1	
Breakfast	1.32
Lunch & Sup	2.48
Snack	0.74

Tier II	
Breakfast	0.48
Lunch & Sup	1.50
Snack	0.20

Administrative Reimbursement rates for Sponsoring Organizations of Day Care Homes.

Homes rates are per home/per month

Home Rates	
Initial 50	111.00
Next 150	85.00
Next 800	66.00
Each Add	58.00

ANNUAL STAFF TRAINING

Administrative Staff ___ Monitor Staff ___ Food Service Staff ___

DATE OF TRAINING _____

Each sponsoring agency or center is required to provide yearly training in CACFP requirements for all Center staff involved in planning, preparing, serving and collecting data regarding meal service.

Check off one or all of the above staff areas that this training pertains to. Separate yearly training can be held for the three staff areas as applicable to their position or completed in one training.

Training REQUIRED

Meal Patterns
Point of Service Meal Counts
Claims Submission
Review Procedures
Reimbursement Systems
Recordkeeping Requirements
Civil Rights

Recommended Training

Nutrition
Safety and Sanitation
Learning Activities Using Foods
Role of Adults at Meal Times
Portion Control
Mealtime Atmosphere

TRAINING GIVEN BY:

AGENDA: TOPICS COVERED

*Attach all pertinent agenda materials

STAFF TRAINED

*Attach sign in sheet as needed

MAINE DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of Child & Family Services
CHILD & ADULT CARE FOOD PROGRAM
Center Reimbursement Claim

IRS#: E CLAIM MONTH: _____ AGREEMENT #:: _____ CLAIM: _____ If original X
If revision #---

NAME: _____

PAYMENT ADDRESS: _____

SECTION A:

1. TYPE OF CENTERS REPORTING:

CHILD DAY CENTERS

HEAD START CHILD CARE CENTERS

ADULT DAY CARE CENTERS

2. CENTERS:

NUMBER OF DAYS OPERATED _____

SPONSORED _____ # OPERATING _____

AVERAGE DAILY ATTENDANCE: _____

3. NUMBER OF CHILDREN OR ADULTS PARTICIPATING IN A MEAL SERVICE THIS MONTH:

FREE: _____ REDUCED-PRICE: _____ PAID: _____ TOTAL: _____

FOR PROFIT CENTERS ONLY: PERCENTAGE OF ENROLLED CHILDREN ELIGIBLE FOR FREE & REDUCED PRICE MEALS _____

4. NUMBER OF MEALS CLAIMED:

BREAKFASTS: _____ LUNCHES: _____ TOTAL SNACKS _____ SUPPERS: _____
(SNACKS AM _____ PM _____ EVE _____)

CERTIFICATION: I (WE) CERTIFY THAT THIS CLAIM IS TRUE AND CORRECT IN ALL RESPECTS; THAT RECORDS ARE AVAILABLE TO SUPPORT THIS CLAIM; THAT IT IS IN ACCORDANCE WITH THE TERMS OF THE EXISTING AGREEMENT(S) AND THAT PAYMENT, THEREFORE, HAS NOT BEEN RECEIVED.

CCI AUTHORITY _____ DATE _____

PREPARER _____

E-MAIL _____ TELEPHONE _____

Submit all claims by the **15th** day following the month being reported to:

DHHS - CACFP, SHS #11, 2 ANTHONY AVENUE, AUGUSTA, ME 04333-0011

DPSSFP-311-R0313

ACTIVITY: CALCULATING AVERAGE DAILY ATTENDANCE FOR A MONTHLY CLAIM

- ❖ At the end of each day, you will determine the total number of CACFP participants who were fed at your site that day.
- ❖ At the end of the reporting month, you will add these daily attendance totals. This number would be your ***total monthly attendance***.
- ❖ You then determine your average daily attendance (ADA) using these numbers.

Using the following example, calculate the average daily attendance .

Jan 3	25
Jan 4	30
Jan 5	35
Jan 6	28
Jan 7	27
Jan 10	36
Jan 11	42
Jan 12	23
Jan 13	21
Jan 14	38
Jan 17	1
Jan 18	45
Jan 19	29
Jan 20	33
Jan 21	41
Jan 24	38
Jan 25	40
Jan 26	31
Jan 27	22
Jan 28	38
TOTAL:	

Total monthly attendance = _____

Divided by number of days operated = _____

Equals ADA _____

. ** Last Step: *Always round up to the next whole number, since we are counting entire people ☺*

Average Daily Attendance: _____

CENTER INCOME ELIGIBILITY FORM COMPLETION

CENTERS:

Copy the current Income Eligibility Form (IEF) for each household /child in care. Ask your families to complete these by a pre-determined deadline. If possible, complete it on site as part of your contract with them to assure it gets back to you.

You cannot force a family to complete the IEF, but can suggest that it's a needed part of keeping your food cost down. This form determines the amount you will be reimbursed. Let families know there are Reduced Price income guidelines within the form. If their family income is over the amount for family size, they can write N/A in the income section and complete the rest as part of the child's enrollment in the CACFP. This form does not leave your center, and is kept in your files as confidential information. CACFP State reviewers will, at center reviews, view your IEF determinations for accuracy.

The full name and age of each child should be on each form. If there are multiple children from one household in care only one form is required. If one of the children have a different last name in the household, it is highly recommended to copy the form and add the copy for the child in your IEF file alphabetically.

Assure that the family has filled in the days, hours and meals in care. This should reflect any times the children may need care. If they typically are in care only afterschool but sometimes there for vacations, etc., ask the parent to note that on the form.

Once returned check the following:

Part I

If any household member receives SNAP, TANF or FDPIR benefits they may check the box in "line a.", adding the case number (the case number that ends with "A" or "T", not their EBT number) into the line that applies to them, (b-d). If this number is provided, they are not required to report income in Part II. While this is the number used for Maine Care, receiving Maine Care alone does not qualify the household for this program. If the "A" number is written in at least one of the three slots go to Part III and assure the parent /guardian completed Part III, printing their name and address and signing and dating the form. They do not need to fill in a 4-digit Social Security if they qualify for TANF, SNAP or FDPIR, and have provided their "A" number.

The Racial/ Ethnic Identity section (BOTH 1. and 2.) must be completed and if the parent/guardian did not fill in the Racial Ethnic Identity, the center staff must make their best guess as to the R/E and initial and date that section.

Center staff should then circle the Childs Eligibility Category as "FREE" and sign and date the form.

This form is approved for one year starting from within the month it is signed by center staff through the final month of the year's timeframe.

If you will use the Free-Reduced and Paid Sheet(FRPsheet) - add the child and their "Free" documentation to this form at this time.

If Part I is not applicable to the family, they must complete Part II.

PART II

The parent /guardian must add all household members, ages of children and wage information into Part II (C), and complete Part III.

Center staff needs to assure the parent /guardian completed Part II and have printed their name and address, and signed and dated the form. A 4-digit Social Security is required.

The Racial/ Ethnic Identity section (BOTH 1 and 2) must be completed and if the parent/guardian does not fill in the Racial Ethnic Identity, the center staff must make their best guess as to the R/E and initial and date that section.

Once the form is returned, use the current **INCOME ELIGIBILITY GUIDELINES SHEET** to determine and calculate whether the wage /income in Part II (C) puts the household in a "Free" category or Reduced Price" category. Proof of income is not required. Do not use just the "Reduced Price" Income guidelines found in the IEF –use the Income Guidelines with both "Free" and "Reduced-Price" to assure you find the children who are to be determined as Free.

If the household is categorized in either the "Free" or "Reduced" category, document the determination on the form, circling either "Free" or "Reduced". Staff must sign and date the form. Add each child by "F" or "R" designation to the FRP Sheet.

If the household income did not qualify the family in the Free or Reduced Price categories, or the family did not add income information into the form, staff should circle "Paid" under the Childs Eligibility Category on the form and sign and date the form. If the last 4 digits of the parent/guardian are not provided, the child must be determined as "Paid".

If the family did not return the form, the staff should add the name and age of the child on the form and initial and date the R/E section after making their best guesstimate at the child's Racial Ethnic Identity. Then they can circle "Paid" under the Childs Eligibility category and note the parent didn't return or complete the form. Add each "Paid" child by designation to the FRP Sheet.

This form is approved for one year starting from within the month it is signed by center staff through the final month of the year's timeframe.

These forms must be updated yearly.

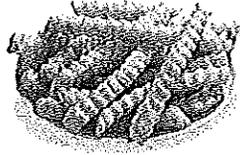
The guidelines for these forms are updated every July 1. You will receive new updated forms before that date.

It is best to keep each child's eligibility form filed alphabetically or in a binder for ease in finding and reviewing the forms.

Check these forms and their determinations carefully as your monthly reimbursement claim is based on the F-R-P determinations made on these forms. You may want to use the Free- Reduced and Paid Sheet to aid in your claim process. As a For profit, this sheet also shows how you monthly calculate that 25% of the children in care are eligible for Free or Reduced Price meals based on license capacity or total enrolled, whichever is less.

Answer Sheet

ACTIVITY: USING THE FOOD BUYING GUIDE TO CALCULATE AMOUNT OF FOOD NEEDED



You are planning to serve $\frac{1}{2}$ cup servings of baked french fries.

You estimate that you will need 45 servings.

Using the Food Buying Guide, calculate how much you will need to purchase.

1. Locate the item in the *Food Buying Guide*.
2. Look in column 4 to check the serving size listed. If it does not match your serving size, you need to convert it.

Serving size in column 4: $\frac{1}{4}$ cup

3. How many of the serving size that you wrote above will you need to get your 45 serving of $\frac{1}{2}$ cup each? $\frac{1}{4} c = 0.25$ $\frac{1}{2} c = 0.50$ (divide $\frac{1}{2}$ by $\frac{1}{4}$)

$$0.5 \div 0.25 = 2 \text{ (Multiply this by the \# of servings you need)}$$

$$2 \times 45 = 90$$

Total servings needed (of amount that was listed in column 4): 90

4. Now look at column 2 and find the purchase unit: pound

and look at column 3 for the number of serving that you will get out of each purchase unit: 16.2

5. Divide the total number of servings needed (from #3) by the number of servings that you get in a purchase unit (from column 3):

of servings needed is 90

Serving per unit is 16.2

$$90 \div 16.2 = 5.55$$

Round up to ensure that enough food is available. 5.75

Answer: $5\frac{3}{4}$ pounds of fries will be needed to have 45 servings of $\frac{1}{2}$ cup each.

Answer Sheet

ACTIVITY: CALCULATING AVERAGE DAILY ATTENDANCE FOR A MONTHLY CLAIM

- ❖ At the end of each day, you will determine the total number of CACFP participants who were fed at your site that day.
- ❖ At the end of the reporting month, you will add these daily attendance totals. This number would be your *total monthly attendance*.
- ❖ You then determine your average daily attendance (ADA) using these numbers.

Using the following example, calculate the average daily attendance .

Jan 3	25
Jan 4	30
Jan 5	35
Jan 6	28
Jan 7	27
Jan 10	36
Jan 11	42
Jan 12	23
Jan 13	21
Jan 14	38
Jan 17	1
Jan 18	45
Jan 19	29
Jan 20	33
Jan 21	41
Jan 24	38
Jan 25	40
Jan 26	31
Jan 27	22
Jan 28	38
TOTAL:	623

Total monthly attendance = 623

Divided by number of days operated = 20

Equals ADA 31.5

*** Last Step: Always round up to the next whole number, since we are counting entire people ☺*

Average Daily Attendance: 32

MAINE CACFP CONTACT INFORMATION

Maine DHHS – CACFP
2 Anthony Avenue, SHS 11
Augusta, ME 04333
Fax: (207) 287-6308

Cindy Chase, Agreement Administrator
Cindy.chase@maine.gov
(207) 624-7916

Kerri Wyman, Agreement Administrator
Kerri.wyman@maine.gov
(207) 624-7960

Tammy Giles, Agreement Administrator
Tammy.l.giles@maine.gov
(207) 624-7925

Carrie Morrell, Financial Resource Specialist
Carrie.m.morrell@maine.gov
(207)624-7930

Maine CACFP Webpage www.maine.gov/dhhs/ocfs/ec/occhs/foodpgm.htm