

Child and Adult Care Food Program Child Care Center Meal Benefit Income Eligibility Form

Part 1. All Household Members

Name of Enrolled Child(ren):		
Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

Part 2. Benefits: If any member of your household received [State SNAP], [FDPIR], or [State TANF cash assistance], provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**
 NAME: _____ CASE NUMBER: _____ - _____

Part 3. If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call **[Your center director, Homeless Liaison, Migrant Coordinator at Phone #]** Homeless Migrant Runaway

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List only household members with income) <i>(Example)</i> Jane Smith	B. Gross income and how often it was received			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
	\$200/weekly _____	\$150/twice a month _____	\$100/monthly _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)
 An adult household member must sign this form. **If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the back of this page.)

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 get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign Here: _____ Print Name: _____
 Date: _____
 Address: _____ Phone Number: _____
 City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: - - _____ I do not have a Social Security Number

Part 6. Participant's ethnic and racial identities (optional)
 Mark one ethnic identity: _____ Mark one or more racial identities: _____

<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander
Don't fill out this part. This is for official use only.		
Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12		
Total Income: _____ Per: <input type="checkbox"/> Week, <input type="checkbox"/> Every 2 Weeks, <input type="checkbox"/> Twice A Month, <input type="checkbox"/> Month, <input type="checkbox"/> Year Household size: _____		
Categorical Eligibility: _____ Eligibility: Free _____ Reduced _____ Denied (Paid) _____ Date Withdrawn: _____		
Reason for Denied: _____		
Temporary: Free _____ Reduced _____ Time Period: _____ (expires after _____ days)		
Determining Official's Signature: _____		Date: _____
Confirming Official's Signature: _____		Date: _____
Follow-up Official's Signature: _____		Date: _____

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

Household size	Yearly
1	\$22,311
2	\$30,044
3	\$37,777
4	\$45,510
5	\$53,243
6	\$60,976
7	\$68,709
8	\$76,442
Each additional person:	\$7,733

Privacy Act Statement: The Richard B. Russell National School Lunch Act 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 Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (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 Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination 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, (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:

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

Email: program.intake@usda.gov

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