

CACFP MEAL INCOME ELIGIBILITY FORM / CHILD CARE

FACILITY NAME: \_\_\_\_\_

**PART 1 – NAME OF ENROLLED CHILDREN** \*OPTIONAL- Participant's ethnic and racial identities \*

Child's Name	Age	Date of Birth	Foster Child Yes /No	Hispanic or Latino Yes / No	American Indian or Alaskan Native	Asian	Native Hawaiian or Other Pacific Islander	White	Black or African American
1				<input type="checkbox"/> Yes <input type="checkbox"/> No					
2				<input type="checkbox"/> Yes <input type="checkbox"/> No					
3				<input type="checkbox"/> Yes <input type="checkbox"/> No					
4				<input type="checkbox"/> Yes <input type="checkbox"/> No					

ADDITIONAL HOUSEHOLD CHILDREN: \_\_\_\_\_ TOTAL NUMBER IN HOUSEHOLD: \_\_\_\_\_

**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 benefits, skip to PART 3.**

Name of individual who receives benefits	Case Number	NOTE: Case number is <b>not</b> the number found on the EBT card or an individual's Social Security number
1. _____	_____	<b>To obtain SNAP Case ID # call: 1-800-482-8988</b>
2. _____	_____	
3. _____	_____	

**PART 3 – Check appropriate box:**  Homeless  Migrant  Runaway  
If a child you are applying for is homeless, a migrant, or a runaway, please contact your local school, Homeless Liaison, or Migrant Coordinator.

**PART 4 – TOTAL HOUSEHOLD GROSS INCOME:** Please identify your income and how often it is received.  
**\*Weekly / Every 2 Weeks / Twice A Month / Monthly / Annual \***

Name of all household members, except children listed above	Gross Income (before deductions)	Welfare, Child Support, or Alimony	Pension, SSI, VA Benefits, Social Security retirement	Additional Income	No Income
1. _____	\$ _____/____	\$ _____/____	\$ _____/____	\$ _____/____	_____
2. _____	\$ _____/____	\$ _____/____	\$ _____/____	\$ _____/____	_____
3. _____	\$ _____/____	\$ _____/____	\$ _____/____	\$ _____/____	_____
4. _____	\$ _____/____	\$ _____/____	\$ _____/____	\$ _____/____	_____

**PART 5 – Signatures and last four digits of Social Security Number are required**

If Part 3 is completed, the adult signing the form must also provide the last four digits of his/her Social Security Number or mark the "I do not have a Social Security Number" box. (See Statement on the back of this page.)  
I certify that all the information provided on this form is true and I understand the following:

- The center or day care home will receive Federal funds based on the information I submit.
- I understand that CACFP officials may verify the information I have submitted.
- I understand that if I purposely submit false information, the participant receiving meals may lose the meal benefit, and I may be prosecuted.

**Please acknowledge you have read and understood the statement above by signing the next page.**

**YOU MUST SIGN AND COMPLETE ADDRESS SECTION ON THE BACK! > > > >**

Valid 1 year from this Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_

City: \_\_\_\_\_

State and Zip Code: \_\_\_\_\_

Last four digits of Social Security Number: XXX-XX-\_\_ \_\_ \_\_ \_\_

 I do not have a Social Security Number

**REQUIRED**
**This Section is to be completed by Child Care Institution – \*DETERMINATION OF ELIGIBILITY\***

Household Size: \_\_\_\_\_

 Total Income: \$ \_\_\_\_\_  Weekly  Every 2 weeks  Twice a Month  Monthly  Yearly

 Categorical Eligibility: \_\_\_\_\_ Date Withdrawn: \_\_\_\_\_ Eligibility:  Free  Reduced  Denied  Tier I  Tier II

Reason: \_\_\_\_\_

Determining Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Confirming Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Follow-up Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Annual Income Conversion:**

- Weekly X 52
- Every 2 Weeks X 26
- Twice A Month X 24
- Monthly X 12

**Refer to the current USDA Income Eligibility Guidelines for making determinations of Free, Reduced, or Paid**

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:** This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating based on race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

**For Use During CACFP Review:**

HNU Representative Signature: \_\_\_\_\_

Date: \_\_\_\_\_