2012 CHILD AND ADULT CARE FOOD PROGRAM ELIGIBILITY APPLICATION

(Revised edition)

NAME OF THE ENROLLED PARTICIPANT ____ **AGE** ______________

OPTIONAL: RACIAL/ETHNIC IDENTITY OF PARTICIPANT

Check one ETHNIC identity:

[ ] Hispanic or Latino [ ] Not Hispanic or Latino

Mark one or more RACIAL identity(ies):
[ ] American Indian or Alaska Native [ ] Asian [ ] Black or African American
[ ] Native Hawaiian or Other Pacific Islander [ ] White

Enrollment Information

***Check (√) each day** the above participant is enrolled for care, the **hours of care** each day, and the **meal type(s)** served:*

DAYS OF CARE: ☐ MON ☐ TUES ☐ WED ☐ THURS ☐ FRI ☐ SAT ☐ SUN

HOURS OF CARE: ___ - ___ ___ - ___ ___ - ___ ___ - ___ ___ - ___ ___ - ___ ___ - ___
Swing / Rotating Shifts: (If Applicable) ___ - ___ ___ - ___ ___ - ___ ___ - ___ ___ - ___ ___ - ___ ___ - ___

MEAL TYPES SERVED: ☐ **BREAKFAST** ☐ **A.M. SUPPLEMENT** ☐ **LUNCH** ☐ **P.M. SUPPLEMENT** ☐ **DINNER**

CHILD CARE FOOD PROGRAM PARTICIPANTS ONLY

OPTION 1A: FOOD STAMPS OR TANF BENEFICIARIES

If you are now receiving Food Stamps or TANF for this child, complete **one** of the following numbers:

FOOD STAMP CASE #________________________________ OR **TANF CASE #**________________________________

OPTION 1B: FOSTER CHILD

If you are applying for a foster child, check the box and list any personal income which has been identified by specific category such as clothing, school fees, allowances, etc.:

FOSTER CHILD ☐ **INCOME $**______________

ADULT FOOD PROGRAM PARTICIPANTS ONLY

OPTION 2: FOOD STAMPS, SSI OR MEDICAID BENEFICIARIES

If you are now receiving Food Stamps, SSI or Medicaid complete **one** of the following numbers:

FOOD STAMP CASE #_________________ **SSI CASE #**__________________ **MEDICAID CASE #**_____________________

OPTION 3: HOUSEHOLD ELIGIBILITY - COMPLETE IF YOU DID NOT COMPLETE OPTION 1A, OPTION 1B, OR OPTION 2

Complete the following information: Household Members, Social Security Numbers and Income.

NAMES OF ALL OTHER HOUSEHOLD MEMBERS: (*Related and Unrelated*)	MONTHLY INCOME *(Complete One Or More - Before Deductions)*				
	MONTHLY (Gross Earnings) WAGES / SALARY	MONTHLY SOCIAL SECURITY PENSIONS RETIREMENT	MONTHLY UNEMPLOYMENT WORKMEN'S COMPENSATION	MONTHLY WELFARE CHILD SUPPORT ALIMONY	MONTHLY ANY OTHER INCOME
1.	$	$	$	$	$
2.	$	$	$	$	$
3.	$	$	$	$	$
4.	$	$	$	$	$
5.	$	$	$	$	$
6.	$	$	$	$	$
7.	$	$	$	$	$
8.					
9.					
10.	$	$	$	$	$

TOTAL NUMBER IN HOUSEHOLD ***(INCLUDE ENROLLED PARTICIPANT):*** _______

TOTAL GROSS HOUSEHOLD INCOME: **$** ________________

ADULT HOUSEHOLD MEMBER SIGNATURE and LAST FOUR DIGITS of SOCIAL SECURITY NUMBER: *(See Privacy Act Statement below)*
An Adult Household Member must sign and date this form, and list the last four (4) digits of his or her Social Security Number.
If you do not have a social security number, mark the box (☒) - "I do not have a Social Security Number".

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that the Food Stamp, TANF, SSI, or Medicaid Number of the enrolled participant is correct, or that all income is reported. I understand that this information is being given for the receipt of Federal funds issued to the day care center based on the information I provide. I understand that CACFP officials may verify this information; and that deliberate misrepresentation may result in the participant losing meal benefits, and I may be prosecuted under the applicable State and Federal laws. ***An Adult Household Member must complete the following:***

Signature: ______________________________________ Address:____

Print name: ______________________________________ City: _______________________ State: ______________ Zip Code: __________

Date: ____________________ Phone Number:______________________________________

Last four (4) digits of Social Security Number: X X X - X X - ___ ___ ___ ___ ☐ **I do not have a Social Security Number**

PRIVACY ACT STATEMENT: The National School Lunch Act requires that, unless the participants' Case Number is provided, you must include the Social Security Number of the adult household member signing the application or indicate that the household member does not have a Social Security Number. Provision of a Social Security Number is not mandatory, but if a Social Security Number is not given or an indication is not made that the signer does not have such a number, the participant cannot be determined eligible for free or reduced priced menus. The Social Security Numbers may be used to identify you for verifying the correctness of information stated on the application. These verifications may include audits, investigations and may include contacting employers to determine income, contacting a Food Stamp or TANF office to determine current certification for receipt of Food Stamps 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 actions if incorrect information is reported. These acts must be told to all household members whose Social Security Numbers are reported on this form.

TO BE COMPLETED BY DAY CARE AGENCY ONLY - DO NOT WRITE BELOW THIS LINE

Determination: Free __________ Reduced __________ Paid __________
Signature of Determining Official:
____ Date___________

TOTAL MONTHLY INCOME $___________________
Conversion factors to figure monthly income: Weekly x 4.33
Twice a month x 2
Every 2 weeks x 2.15

2011-2012 CHILD AND ADULT CARE FOOD PROGRAM
LETTER TO PARENT/PARTICIPANT

Dear Parent/Participant:

Our agency depends on Child and Adult Care Food Program funds to provide meals at no separate charge to all participants.

This information is necessary so that we may determine if participants are eligible for the Child and Adult Care Food Program. This form will be placed in our files and treated as confidential information.

The income that you report must be the total gross income received by all members of your household. If during the year, there are decreases in your family size or increases in your income that exceed $50 per month or $600 per year, you must report these changes to the center so that appropriate eligibility adjustments can be made. Also, if you become unemployed, the participant may be eligible for the free or reduced-price meal category during the period of unemployment.

The "Eligibility Income Scale" for reduced-price meals is included in this letter for your information. If your income is less than or equal to these reduced-priced standards, the participant is eligible for free or reduced-price meals from the Child and Adult Care Food Program which means increased reimbursement for our center and increased nutritional benefits for the participant.

Please complete, sign and return the form so that our center may receive maximum reimbursement.

Your cooperation is vital and appreciated.

The Child and Adult Care Food Program is a federal program of the Food and Nutrition Service, United States Department of Agriculture. In accordance with Federal law and U.S. Department of Agriculture (USDA) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint alleging discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue SW, Washington, DC 20250-9410 or call, toll free, (866) 632-9992 (Voice). TDD users can contact USDA through local relay or the Federal Relay at (800) 877-8339 (TDD) or (866) 377-8642 (relay voice users). USDA is an equal opportunity provider and employer.

_______________________________ **X**_______________________________

(Name of Day Care Center) *(Signature of Day Care Center Representative)*

TO APPLY, YOU MUST COMPLETE ONE OF THREE OPTIONS.

1. List the Name of the participant *(First and Last Names).*
2. Complete the Days, Hours of Care, and the meals types served to the enrolled participant. *(One time requirement for Adult Day Care participants.)*

Option 1A or 1B - CHILD CARE PARTICIPANTS ONLY:

If you receive Food Stamps or TANF benefits for the participant, list the Food Stamp or TANF Case Number and Sign and Date the form.

If you are applying for a **Foster Child** who is the legal responsibility of the welfare agency or court, Check the Box and Sign and Date the form.

A FOSTER CHILD'S PERSONAL USE INCOME is defined as follows:

a) Funds received from a welfare agency, which can be identified for personal use of the child. Where funds provided by the welfare agency are specified by agency, i.e., funds for shelter and care; special needs funds; and funds for personal needs such as clothing, school fees, allowances, etc., only those funds that can be identified as personal use funds shall be considered as income.

b) Money received in hand from any source. This includes, but is not limited to, funds received from trust accounts, monies provided by the child's family for personal use and earnings from employment other than occasional or part-time (e.g., paper routes, baby-sitting).

Option 2 – ADULT CARE PARTICIPANTS ONLY:

If you receive Food Stamps, SSI or Medicaid benefits for the participant, indicate the Food Stamp, SSI or Medicaid Case Number and Sign and Date the form.

Option 3 – CHILD CARE AND ADULT PARTICIPANTS:

If you do not receive Food Stamps, TANF, SSI or Medicaid benefits for the participant, you must complete:

3. Names of all *(Related or Unrelated)* household members
4. List the household income *(Monthly Gross Earnings)* for each household member
5. Total number in household *(#1 + #2 above).*
6. Total gross income of all household members.
7. Sign, date, and list the last four (4) digits of the social security number for the Adult Household Member signing the application, or indicate that the Adult Household Member signing the application does not possess a social security number.
8. Print name of adult household member signing the application.
9. Complete the full address and telephone number of the Adult Household Member signing the application.

ELIGIBILITY INCOME SCALE
Effective from July 1, 2011 to June 30, 2012

HOUSEHOLD SIZE	REDUCED		
	ANNUAL	MONTHLY	WEEKLY
1	$14,158 - $20,147	$1,181 - $1,679	$274 - $ 388
2	$19,124 - $27,214	$1,595 - $2,268	$369 - $ 524
3	$24,090 - $34,281	$2,009 - $2,857	$465 - $ 660
4	$29,056 - $41,348	$2,423 - $3,446	$560 - $ 796
5	$34,022 - $48,415	$2,837 - $4,035	$656 - $ 932
6	$38,988 - $55,482	$3,250 - $4,624	$751 - $1,067
7	$43,954 - $62,549	$3,664 - $5,213	$847 - $1,203
8	$48,920 - $69,616	$4,078 - $5,802	$942 - $1,339
Each Additional Family Member	+7,067	+589	+136