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CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Institution or Facility Name:				
Part 1. Name of Child(ren) Enrolled:				
		OF A WELFARE AG	ER CHILD (THE LEGA SENCY OR COURT) LISTED BELOW ARE	
Full names of all household members		CHILDREN, SKIP T	O PART 5 TO SIGN T	HIS FORM.
Part 2. Benefits: If any member of your and case number for the person who red NAME:	ceives benefits. If no c	ne receives these b	enefits, skip to part	3.
Part 3. If any child you are applying for is	homeless, a migrant,	or a runaway, call the	e State agency for ins	structions.
Part 4. Total Household Gross Income	—You must tell us h	ow much and how o	often (whole dollar a	mounts, please)
Total number in household:	B. Gross income and I will be accepted as repr			\$0. Any field left blank
A. Name (List only household members with income)	Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All other income
(Example) Jane Smith	\$200/weekly	\$150/twice a month_	\$100/monthly	\$/
	\$/	\$/	\$/	\$/
	\$/	\$/	\$/	\$/
	\$/	\$/	\$/	\$/
	\$/	\$/	\$/	\$/
	\$/	\$/	\$/	\$/
This section required for all forms listing in Last four digits of Social Security Number: X		☐ I do not have a So	cial Security Number	•
Part 5. Signature (Adult must sign) An adult household member must sign to	his form.			
I certify that all information on this form i will get Federal funds based on the infor understand that if I purposely give false be prosecuted.	mation I give. I unders	tand that CACFP offi	cials may verify the ir	nformation. I
Sign here:	rint name:			
Date:				
		hone Number:		
		zate: Zip Code:		

Part 6. Participant's ethnic and racial identities				
Mark one ethnic identity:	Mark one or more racial identities:			
☐ Hispanic or Latino☐ Not Hispanic or Latino	☐ Asian ☐ White	☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander		
Part 7. Decline to provide information				
I choose not to provide information about my household size and income.				
Signature of Adult Household Member Date		Date		
This Section is to be completed by the Child Care Institution – Determination of Eligibility				
Completion of this section is <u>required</u> for the institution to claim meals at the free or reduced rate for the child/children listed in Part 1: Name of Child(ren) Enrolled.				
Number of persons in the household:				
Total income \$ Per:				
Categorical Eligibility: ☐Free	Reduced	□Paid □Tier I □Tier II		
Required: Determining Official's Signature: Date:				
Additional official signatures are recommended but not required.				
Confirming Official's Signature:	Date:			
Follow-up Official's Signature: _	Date:			

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), Food Distribution Program on Indian Reservations (FDPIR), or Temporary Assistance for Needy Families (TANF) case number for the participant 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, audiotape, 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 (1) Mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) Fax: (202) 690-7442; or (3) Email: program.intake@usda.gov. This institution is an equal opportunity provider."

Head Start: Children who are enrolled in the Federal Head Start Program receive meal benefits in the CACFP without further application or eligibility determination. Acceptable documentation includes a current approved Head Start application or a written, signed and dated statement or roster from a Head Start official. [USDA Memos CACFP 7-2008 and CACFP 10-2008]