Child and Adult Care Food Program

Dear Parent or Guardian:

Please fill out the attached form and return it as soon as possible. The form will be kept in our files and treated as confidential. The information you give will help us get money for the meals served to children in our program through the U. S. Department of Agriculture's Child and Adult Care Food Program.

If you get SNAP (Food Stamps) or TANF funding, fill out Part 2A of the form with your case number.

If you have a foster child in our program (he/she must be a legal ward of the State), please fill out Part 2C of the form.

If you do not have a SNAP (Food Stamps) number, TANF case number, or a foster child, you **must** fill out Part 2B of the form. Include the income(s) of all people living in your household, related or not (such as grandparents, other relatives, or friends). You must include yourself and all children who live with you. An adult household member *[parent/legal guardian]* must sign and date the form and provide their social security number.

The income you report must be last month's total household income, before any taxes or anything else is taken out, for each household member. List the amount you normally get. For example, if you normally get $1,000 each month, but you missed some work last month and only got $900, put down that you get $1,000 per month.

All forms must be signed and dated in Part 3.

Thank you for taking the time to fill out this form. If you need any help, please contact us at (302)422-6565.

INCOME ELIGIBILITY GUIDELINES FOR REDUCED PRICE MEALS
Effective Date July 1, 2013 – June 30, 2014

FAMILY SIZE	YEARLY	MONTHLY	WEEKLY
1	$21,257	$1,772	$409
2	$28,694	$2,392	$552
3	$36,131	$3,011	$695
4	$43,568	$3,631	$838
5	$51,005	$4,251	$981
6	$58,442	$4,871	$1,124
7	$65,879	$5,490	$1,267
8	$73,316	$6,110	$1,410
For each additional household member, add:	+$7,437	+$620	+$144

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 Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 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.

Child and Adult Care Food Program
Income Eligibility Form

PART 1 *(This part must be completed for all participants. Enter the participant(s) name and information.)*

Participant's Name: _____ **DOB:** _____
Last First Middle Initial

White **Black** **Hispanic/Latino** **Am. Indian/Alaskan** **Native Hawaiian/Alaskan** **Asian/Pacific Islander**
(Circle one – needed for statistical reporting)

Participant's Name: _____ **DOB:** _____
Last First Middle Initial

White **Black** **Hispanic/Latino** **Am. Indian/Alaskan** **Native Hawaiian/Alaskan** **Asian/Pacific Islander**
(Circle one – needed for statistical reporting)

Start Date: _____ **Arrival Time:** _____ **AM/PM** **Departure Time:** _____ **AM/PM** **Shift Work:** **Yes/No**

***Normal* days of week Participant(s) is/are in care** (circle all that apply): **Mon** **Tues** **Wed** **Thurs** **Fri** **Sat** **Sun**

Meals eaten at Providers/Center: (Circle all that apply. CACFP provides reimbursement for up to 2 approved meals and one snack per day/participant):
Breakfast **AM Snack** **Lunch** **PM Snack** **Supper** **Evening Snack**

PART 2A – HOUSEHOLDS NOW GETTING SNAP OR TANF: *Complete this Part; skip to Part 3 to sign and date this form.*
SNAP Case Number (i.e., Food Stamp): _____ **TANF Case Number:** _____

PART 2B – FOSTER CHILD - Check box if a foster child: ☐* (The legal responsibility of a welfare agency or court.) Include personal income earned by the foster child only. Foster payments received by the family from the placing agency are not considered income and do not need to be reported. Write the child's income: _____ ☐ Month/☐Year. ***A copy of the State or local agency document indicating a child's foster status is required to be on file at the child care institution.** *Complete this part; skip to Part 3 to sign and date this form.*

PART 2C – HOMELESS - Check Box if homeless: ☐ *Complete this part; skip to Part 3 to sign and date this form.*

PART 2D – HOUSEHOLD INCOME – *If you do not need to complete Part 2A, 2B or 2C, complete this Part and Part 3 to sign and date this form.*
NAMES CURRENT INCOME **(Please indicate by Week/Bi-Wk/2x's Mo/Month/Year)**

List Names of All Household Members (Attach Any Additional Members)	Earnings from Work (Before Deductions) Job 1	Welfare, Child Support, Alimony	Payments from Pensions, Retirement, Social Security	Earnings from Job 2 or any Other Income
(Example) - Jane Smith	$200/weekly	$150/twice a month	$100/monthly	$
1	$	$	$	$
2	$	$	$	$
3	$	$	$	$
4	$	$	$	$
5	$	$	$	$

PART 3 – SIGNATURE and LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER: An adult household member must **sign and date** this form before it can be approved. If Part 2D 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.)

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct, that the SNAP or TANF Number is correct, and that all income is reported. I understand that this information is being given for the receipt of Federal funds; that institution officials may verify the information on the statement, and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

Printed Name of Adult _____ **Signature of Adult** _____ **Date** _____

Home Address: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Last four digits of Social Security Number: *_*_*_-*_*_-____ ☐ I do not have a Social Security Number

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SPONSOR USE ONLY: Categorical Eligibility (If Yes, Check One): ☐ SNAP (Food Stamp) Household ☐ TANF Household ☐ Head-Start ☐ ECAP ☐ Foster Child(ren) ☐ Homeless Participant(s)

DATE WITHDRAWN: _____

Total Family Income: _____ Family Size: _____ (Include all Participants)
*Monthly Income Conversion: **Weekly x 52; Every Two Weeks x 26; Twice a Month x 24; Monthly x 12***

ELIGIBILITY - Based on the information provided this application will be:
☐ Approved FREE ☐ Approved REDUCED ☐ Denied – The meals will be claimed in the PAID category.

Temporary Approval: ☐ Approved Free. **This application reported zero income. Temporary approval is good for 45 days and expires on _____. Re-evaluate income after that date.**

Determining Official Signature: _____ Review/Effective Date: _____

Revised: **4/18/11**