

**CACFP ELIGIBILITY APPLICATION
CHILDREN ENROLLED IN FAMILY DAY CARE HOMES**

PART I

Child's Name: _____
Last _____ First _____ M.I. _____ Date of Birth _____

Child's Name: _____
Last _____ First _____ M.I. _____ Date of Birth _____

Provider's Name: _____

PART 2A - HOUSEHOLDS NOW GETTING FOOD STAMPS, TANF/WORK FIRST, FDPIR, NATIONAL SCHOOL LUNCH OR WIC BENEFITS: Complete this part and sign the statement in PART 3 - DO NOT complete PART 2B. If a child or a child's parent is participating in or subsidized under a Federally or State supported child care or other benefit program with an income eligibility limit that does not exceed the eligibility standard for free or reduced price meals, meals served to the child are automatically eligible for tier I reimbursement, subject to the completion of the application.

Food stamp case #: _____ WIC#: _____
 TANF/Work First identification #: _____ Receives Free/Reduced Priced School Lunch (NSLP) (Check if applies)
 FDPIR identification #: _____ Receives Free/Reduced Priced School Breakfast (SBP) (Check if applies)
(Food Distribution Program on Indian Reservations)
 Federally funded Head Start Program (Check if applies)

PART 2B - ALL OTHER HOUSEHOLD MEMBERS: If you did not complete PART 2A, complete this PART and PART 3.

NAMES		CURRENT INCOME/FREQUENCY - (Last Month)		
Names of All Household 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

PART 2C - FOSTER CHILD: Complete this PART and PART 3. If this is a foster child check here () and write the child's income and how often it is received here: \$ / . In certain cases, foster children are eligible for free and reduced-price meals regardless of household income.

PART 3 - SIGNATURE AND SOCIAL SECURITY NUMBER: An adult household member must sign the statement before it can be approved. I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds; that Program officials may verify the information on the application and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal criminal laws.

Signature of Adult: _____ (Required) Social Security #: _____ (Required (all 9 digits) for households qualifying by income)

Printed name of Adult: _____ Date Signed: _____

Home Address _____ Zip Code _____ Home Telephone _____ Work Telephone _____

PART 4 - ETHNIC IDENTITY: (Please check one).

Hispanic or Latino Not Hispanic or Latino

RACE OF PARTICIPANT: (Please check one or more).

White Black or African American American Indian or Alaskan Native
 Asian Native Hawaiian or Other Pacific Islander

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 your child for free or reduced price meals. You must include the social security number of the adult household member who signs the application. The social security number is not required when your apply on behalf of a foster child or you list a Food Stamp, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child 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 your child is eligible for free or reduced price meals and for administration and enforcement of the Program. If a child is a Head Start participant, the child is automatically eligible to receive free Program meal benefits, subject to submission by Head Start officials of a Head Start statement of income eligibility or income eligibility documentation.

For Sponsoring Organization Use Only:

MONTHLY INCOME CONVERSION: WEEKLY X 4.33 EVERY 2 WEEKS X 2.15 TWICE A MONTH X 2

Total family income: _____ Family size: _____

Tier I _____ Eligible: _____

Tier II _____ Not Eligible: _____

Determining Official Signature: _____ Date: _____

For state use only:	
Verified by: _____	
Date: _____	
Verified classification: <input type="checkbox"/> Free <input type="checkbox"/> Reduced <input type="checkbox"/>	
Denied	

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Please complete the Child and Adult Care Food Program Eligibility Application using the instructions below. Sign the statement and return it to the sponsoring organization listed below. Call the organization if you need help: #_

Dear Parent/Guardian:

Your day care provider participates in the Child and Adult Care Food Program (CACFP) funded by the U.S. Department of Agriculture and administered by the North Carolina Department of Health and Human Services. Please help us comply with the CACFP requirements by completing, signing and returning the attached income statement to the address provided. This information is necessary so that your day care provider may be paid for the meals served to the children in their care. All children in our program receive their meals free of charge, but the income eligibility category determines the amount of funding your day care provider will receive. The information you provide on this form will be confidential and will **NOT** be shared with your day care provider or anyone else without your permission.

Complete the application as follows:

- **HOUSEHOLD MEMBERS:** List the name of the enrolled child(ren), and the child's parent(s) or guardian, and any other dependent children who live in the household.
- **FOOD STAMPS, TANF/WORK FIRST, FDPIR, WIC, FREE/REDUCED PRICE SCHOOL LUNCH:** If a household member is currently receiving benefits from any of these programs, provide the program case/identification number as requested. Do not complete Part 2B.
- **CURRENT INCOME:** List the amount of income each person earned **last** month (**BEFORE**) deductions for taxes, social security, etc.), the frequency of income, and where it is from, such as wages, retirement, or welfare. If any household member's income last month was higher or lower than usual, list that person's usual average monthly income.
- **SIGNATURE:** An adult household member must sign the income eligibility application.
- **SOCIAL SECURITY NUMBER:** List the social security number of the adult who signs the income eligibility statement. If that adult does not have a social security number, print "None"

**EFFECTIVE JULY 1, 2009 - JUNE 30, 2010
REDUCED GUIDELINES**

<u>HOUSEHOLD SIZE</u>	<u>YEARLY</u>	<u>MONTHLY</u>	<u>TWICE PER MONTH</u>	<u>EVERY TWO WEEKS</u>	<u>WEEKLY</u>
1	20,036	1,670	835	771	386
2	26,955	2,247	1,124	1,037	519
3	33,874	2,823	1,412	1,303	652
4	40,793	3,400	1,700	1,569	785
5	47,712	3,976	1,988	1,836	918
6	54,631	4,553	2,277	2,102	1,051
7	61,550	5,130	2,565	2,368	1,184
8	68,469	5,706	2,853	2,634	1,317
For each Household member add:	+6,919	+577	+289	+267	+134

You may submit a program eligibility application any time during the fiscal year. Participants having family members who become unemployed are eligible for free or reduced-price meals during the period of unemployment, provided that the loss of income causes the family's income during the period of unemployment to be within the eligibility standards for those meals.

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 (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

There is now an affordable health insurance program for children, Health Choice, offered by the State of North Carolina. Health Choice is a comprehensive health plan which covers both hospitalization and outpatient care, including preventive dental, vision, and hearing benefits. This new health plan is intended for children whose parents' income is too high to qualify for Health Check, the state Medicaid program. Applications for Health Choice will be available beginning in October 1998. You may pick up applications from your local health or county social services departments. Get more information on either Health Choice or Health Check by calling this toll free phone number: (800) 367-2229.

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PART 1 – PARTICIPANT’S INFORMATION: Complete this part.

- (1) Print the name of each child enrolled in the Day Care Home.
- (2) Print the name of the Day Care Home provider.

PART 2A - HOUSEHOLD GETTING FOOD STAMPS, TANF/WORK FIRST, FDPIR, NATIONAL SCHOOL LUNCH, SCHOOL BREAKFAST, HEADSTART OR WIC BENEFITS:

Complete this PART and PART 3.

- (1) List your current food stamp case number or your TANF/Work First, FDPIR, or WIC identification number, or check yes to indicate that your child receives free/reduced priced school lunch. Do not complete Part 2B.
- (2) An adult household member must sign the statement in PART 3.

PART 2B - HOUSEHOLD INCOME: Complete this PART and PART 3

- (1) List the names of household members.
- (2) For each household member provide the gross income (the amount before taxes or any other deductions), the frequency of income (i.e., weekly, every two weeks, twice a month, or monthly) received **last month** for each household member, and where it came from, such as earnings, welfare, pensions, and other income (refer to examples below for types of income to report). If any amount last month was more or less than usual, write the person’s usual income.
- (3) An adult household member must sign this income eligibility statement and give his/her social security number in PART 3.

PART 2C - FOSTER CHILD: Complete this PART and PART 3 for each foster child living in your home and enrolled in the center.

PART 3 - SIGNATURE AND SOCIAL SECURITY NUMBER: All households complete this PART.

- (1) All eligibility statements must have the signature of an adult household member;
- (2) The adult household member who signs the statement must include his/her full social security number. If he/she does not have a social security number, write “none”. If you listed a food stamp, TANF/Work First, WIC, or FDPIR number a social security number is not needed.

PART 4 – ETHNIC/RACIAL IDENTITY: Complete the Ethnic/Racial identity question.

INCOME TO REPORT

<u>Earnings from Employment</u>	<u>Pensions/Retirement/Social Security</u>	<u>Other Income</u>	
Wages/salaries/tips	Pensions	Disability benefits	
Strike benefits	Supplemental security income		Cash withdrawn
from savings			
Unemployment compensation	Retirement income	Interest/dividends	
Worker’s compensation	Veteran’s payments		Income from
estates/trusts/			
Net income from self-owned	Social security	investments	
business or farm		Regular contributions from	
		persons not living in the	household
<u>Welfare/Child Support/Alimony</u>	<u>Military Households</u>	Net royalties/annuities/	
Public assistance payments	All cash income, including military	net rental income	
Welfare payments	housing/uniform allowances. Does		
Alimony/Child support payments	not include “in-kind” benefits NOT		Any other income
	paid in cash (base housing, clothing,		
	food, medical care, etc.)		

Foster Child’s Income

ONLY funds from welfare agency identified by category for personal use of child (clothing, school fees, etc.), funds from child’s family for personal use and earnings from other than occasional or part-time employment. DO NOT COUNT funds from welfare agency for shelter, care, etc.

Name and Address of Sponsoring Organization