

**CACFP ELIGIBILITY APPLICATION - FAMILY DAY CARE HOMES
PROVIDER'S INCOME and PROVIDER'S OWN CHILDREN**

PART IA: Provider's Name:

PART IB : Complete this part if you are claiming your own children.

Child's Name:

Last _____ First _____ M.I. _____ Date of Birth _____

Child's Name:

Last _____ First _____ M.I. _____ Date of Birth _____

PART 2A - HOUSEHOLD NOW GETTING SNAP, TANF, or FDPIR, 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.

SNAP case #: _____ TANF identification #: _____

FDPIR identification #: _____
(Food Distribution Program on Indian Reservations)

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 (). Foster children are eligible for free and reduced-price meals regardless of household income. Households with foster and non-foster children may choose to include the foster child as a household member, as well as any personal income earned by the foster child, on the same household application that includes their non-foster children

PART 3 - SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER:

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 on the application may subject me to prosecution under applicable state and federal criminal laws.

Signature of DCH Provider: _____ Last Four Digits of Social Security #: _____
(Required) (Required (last 4 digits) for households qualifying by income)

Printed name of DCH Provider: _____ 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 last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a SNAP, 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: Verification of SNAP, TANF or FDPIR household categorically eligible for program benefits:

() YES () NO

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:

Sponsor Signature: _____ Date: _____

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

**CACFP ELIGIBILITY APPLICATION INSTRUCTIONS
FAMILY DAY CARE HOMES**

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: #

PART 1A: PROVIDER INFORMATION: Complete this part.

- (1) Print the name of the Day Care Home provider.

PART 1B : Complete this part if you are claiming your own children.

PART 2A : HOUSEHOLD GETTING SNAP, TANF, or FDPIR BENEFITS:

Complete this PART and PART 3.

- (1) List your current SNAP, TANF, or FDPIR case number. 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) Write the amount of income (the amount before taxes or anything else is taken out), 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 3 - SIGNATURE AND LAST FOUR DIGITS OF THE 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 the last four digits of his/her social security number. If he/she does not have a social security number, write "none". If you listed a SNAP, TANF, or FDPIR number a social security number is not needed.

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

INCOME TO REPORT

Earnings from Employment

Wages/salaries/tips
Strike benefits
Unemployment compensation
Worker's compensation
Net income from self-owned business or farm

Welfare/Child Support/Alimony

Public assistance payments
Welfare payments
Alimony/Child support payments

Pensions/Retirement/Social Security

Pensions
Supplemental security income
Retirement income
Veteran's payments
Social security

Military Households

All cash income, including military housing/uniform allowances. Does not include "in-kind" benefits NOT paid in cash (base housing, clothing, food, medical care, etc.)

Other Income

Disability benefits
Cash withdrawn from savings
Interest/dividends
Income from estates/trusts/investments
Regular contributions from persons not living in the household
Net royalties/annuities/net rental income
Any other income

Name and Address of Sponsoring Organization

Dear Day Care Home Provider:

You are participating 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 as soon as possible to your sponsor. This information is necessary so that you may be paid for the meals served to the children in your care. All children in our program receive their meals free of charge, but the income eligibility category determines the amount of funding you will receive. The information you provide on this form will be confidential and will **NOT** be shared with anyone else without your permission.

Complete the application as follows:

- **PROVIDER’S NAME:** Insert your name.
- **CHILDREN:** Complete Part 1B if you are claiming your own children.
- **SNAP, TANF/WORK FIRST, FDIPIR:** 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.
- **HOUSEHOLD MEMBERS:** Complete Part 2B if you do not complete Part 2A. List household members, the name of the enrolled child(ren), and any other dependent children who live in the household.
- **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.
- **LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER:** List the last four digits of 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, 2010 - JUNE 30, 2011
REDUCED GUIDELINES**

HOUSEHOLD SIZE	YEARLY	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY
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 Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (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.

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.