

2012 CHILD AND ADULT CARE FOOD PROGRAM ELIGIBILITY APPLICATION

(Revised edition)

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| NAME OF THE ENROLLED PARTICIPANT _____ | | AGE _____ |
| <i>OPTIONAL: RACIAL/ETHNIC IDENTITY OF PARTICIPANT</i> | | |
| Check one ETHNIC identity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino | | Mark one or more RACIAL identity(ies): <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> 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: <input type="checkbox"/> MON <input type="checkbox"/> TUES <input type="checkbox"/> WED <input type="checkbox"/> THURS <input type="checkbox"/> FRI <input type="checkbox"/> SAT <input type="checkbox"/> SUN | | |
| HOURS OF CARE: _____ - _____ _____ - _____ _____ - _____ _____ - _____ _____ - _____ _____ - _____ | | |
| Swing / Rotating Shifts: (If Applicable) _____ - _____ _____ - _____ _____ - _____ _____ - _____ _____ - _____ _____ - _____ | | |
| MEAL TYPES SERVED: <input type="checkbox"/> BREAKFAST <input type="checkbox"/> A.M. SUPPLEMENT <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SUPPLEMENT <input type="checkbox"/> DINNER | | |

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| 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 <u>one</u> 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 <input type="checkbox"/> | INCOME \$ _____ |

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| ADULT FOOD PROGRAM PARTICIPANTS ONLY | |
| OPTION 2: FOOD STAMPS, SSI OR MEDICAID BENEFICIARIES | |
| If you are now receiving Food Stamps, SSI or Medicaid complete <u>one</u> of the following numbers: | |
| FOOD STAMP CASE # _____ | SSI CASE # _____ MEDICAID CASE # _____ |

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| 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. | | | | | |
| | 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: | | | | \$ _____ | |

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| 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: <input checked="" type="checkbox"/> X X X - X X - _____ <input type="checkbox"/> 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.

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| 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 |