Child and Adult Care Food Program
FAMILY DAY CARE
2025 ELIGIBILITY APPLICATION

PROVIDER'S NAME _____

NAME OF THE ENROLLED PARTICIPANT_____BIRTHDATE: _____/ _____/ _____

OPTION 1A: SNAP OR TANF BENEFICIARIES

If you are now receiving SNAP or TANF for this child, complete one of the following numbers:

SNAP CASE #_____ OR TANF CASE #_____

OPTION 1B: FOSTER CHILD

If this is a foster child, check the box and list any personal income the child receives and identify by specific category such as clothing, school fees, allowances, etc.:

FOSTER CHILD ☐ INCOME $ _____ HOW OFTEN IS IT RECEIVED? _____

OPTION 2: STATE OR FEDERAL PROGRAMS WHICH MEET THE USDA CACFP INCOME ELIGIBILTY CRITERIA

If this applies to you, complete and sign the statement below.

PROGRAM NAME: _____ CASE NUMBER: _____

OPTION 3: HOUSEHOLD ELIGIBILITY

If you did not complete OPTION 1A-B & 2, complete the following information: Household Members, Social Security Numbers and Income.

NAMES OF ALL HOUSEHOLD MEMBERS: *(Do Not Include Foster Children)*	**MONTHLY INCOME** (Before Deductions) COMPLETE ONE OR MORE				
	MONTHLY (Gross Earnings) WAGES / SALARY	MONTHLY SOCIAL SECURITY PENSIONS RETIREMENT	MONTHLY UNEMPLOYMENT WO RK ME N 'S COMPENSATION	MONTHLY WELFARE CHILD SUPPORT ALIMONY	MONTHLY ANY OTHER INCOME
1.	$	$	$	$	$
2.	$	$	$	$	$
3.	$	$	$	$	$
4.	$	$	$	$	$
5.	$	$	$	$	$
6.	$	$	$	$	$

Monthly

TOTAL NUMBER IN HOUSEHOLD *(INCLUDE ENROLLED PARTICIPANT):* _____

TOTAL GROSS HOUSEHOLD INCOME: **$** _____

SIGNATURE AND SOCIAL SECURITY NUMBER: 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 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 understar 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 ar Federal laws. ***An Adult Household Member must complete the following:***

SIGNATURE:

(Signature Of Adult Household Member) _____ *(Household Address)* _____

(Print Name Of Adult Household Member) _____

Last four (4) digits of Social Security Number: ** ** ** - ** ** - _____

☐ **I do not have a Social Security Number**

_____ _____ _____

(Date Signed) *(Home Telephone)* *(Work Telephone)*

Race/Ethnic Identity (optional):

TOTAL	ETHNICITY		RACE:				
	Hispanic or Latino	Not Hispanic or Latino	American Indian or Alaskan Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	White
ENROLLED PARTICIPANTS							
GEOGRAPHIC AREA							

PRIVACY ACT STATEMENT: The Richard B. Russell 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.

FOR SPONSORING ORGANIZATION USE ONLY DO NOT WRITE BELOW THIS LINE

☐ **Check if This Application is for the Provider's Own Child**

DETERMINATION:

☐ **Eligible = (Tier 1)** ☐ **Ineligible = (Tier II)**

CLASSIFICATION OF HOME:

(Complete this section if the application is for the Provider)

☐ **TIER I:** ☐ ***A (Income)**** ☐ ***B (School)*** ☐ ***C (Census)***

☐ **TIER II:** ☐ ***L (Low Rates)*** ☐ ***M (Mixed Rates)***

**Categorically Eligible*

Name of Determining Official: _____ _____ _____/ _____/ _____

(Print name) (Signature) (Date)

2024-2025 CHILD AND ADULT CARE FOOD PROGRAM – FAMILY DAY CARE
LETTER TO PARENT/GUARDIAN/PROVIDER

Dear Parent/Guardian/Providers,

Your child is enrolled at the home of _____, a Provider who is participating in the U.S. Department of Agriculture's Child and Adult Care Food Program (CACFP) through an agreement with our agency. Through this agreement, your Provider is able to claim reimbursement for the meals served to your child while in care. The reimbursement for meals served to children in family day care homes is based on a two-tiered structure. In order to qualify for the higher, Tier I rate or the lower Tier II rate, for meals served to children enrolled in the day care program, the Provider must meet the following criteria:

Tier I Household: ***(Higher Rate)*** – The Provider home must either: **1)** be located in an area of economic need as determined by school enrollment or census data or **2)** establish individual economic need through the FDCFP process of application for free and reduced price meals. If the home is not located in an area determined eligible for Tier 1 rates, and the Provider chooses not to complete this form, the home is only eligible for the lower Tier II rates. If the Provider would like to claim meals served to provider's own or foster child and/or believes the home qualifies for Tier 1 rates, although the Provider home is not located in an area determined economically eligible, the Provider is required to complete this form.

Providers Only: *You must report all household income, not just your day care business income. We are required by law to verify the information stated on your application. You may attach a copy of your most recent tax return, or you may submit documentation for last month. This includes payment statements from salaried work and statements pertaining to other forms of income. For your own income from your child care business, you must submit documentation of your gross income for last month, along with receipts of your business expenses, so that we can verify your net business income.*

If you have already been classified as a Tier I home because your home is located in an area determined to be economically eligible, you do not have to complete this form ***unless you would like to also claim meals served to your own child.***

Tier II Household*: **(Lower Rate)* –** The Provider will be reimbursed at the lower Tier II rate for meals served to your child if:

1) You do not live in an area established as one of economic need.
2) You choose not to complete this form.
3) Do not qualify for free or reduced-price meals.

Please complete, sign and return the enclosed form as soon as possible. This information is necessary to determine the rates of reimbursement the Provider will receive for the meals serve to your child. This form will be placed in our files and treated as confidential information. The "Eligibility Income Scale" for reduced-price meals is included in this letter for your information. If your income is less than or equal to these reduced-price standards, the participant is eligible for free or reduced-price meals from the Child and Adult Food Program which means increased reimbursement for the Provider and increased nutritional benefits for your child. The income that you report must be the total gross income received by all members of your household. If during the year, there are decreases in your family size or increase in your income, which exceed $50 per month or $600 per year, you must report these changes to the center so that appropriate eligibility adjustments can be made. Also, if you become unemployed, the participant may be eligible for the free or reduced-price meal category during the period of unemployment.

INSTRUCTIONS FOR COMPLETING THE FORM

Option 1A: If you receive SNAP, TANF for the child, indicate your SNAP, TANF, case number and sign and date the form.

Option 1B: If you are applying for a foster child who is the legal responsibility of the welfare agency or court, you may check the box, fill in the blanks, submit supporting documentation, and sign and date the form. A FOSTER CHILD 'S PERSONAL USE INCOME is defined as follows:

1. Funds received from a welfare agency, which can be identified for personal use of the child. Where funds provided by the welfare agency are specified by agency, i.e., funds for shelter and care; special needs funds; and funds for personal needs such as clothing, school fees, allowances, etc., only those funds that can be identified as personal use funds shall be considered as income.
2. Money received in hand from any source. This includes, but is not limited to, funds received from trust accounts, monies provided by the child's family for personal use and earnings from employment other than occasional or part-time (e.g., paper routes, baby-sitting).

Option 2: If you or your child participates in, or is subsidized under, a Federal 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, your child is "categorically eligible". This means your Provider is automatically eligible to receive the Tier I higher rates for the meals served to your child. Indicate the name of the program and your case number, and sign and date the form. Federal categorically eligible programs qualifying a child enrolled in a Tier II day care home are:

National School Lunch Program and School Breakfast Program
Special Supplemental Nutrition Program for Woman Infants and Children (WIC).
Federally Funded Head Start Participants
Subsidized Day Care (i.e. Work First New Jersey)

Option 3: If you do not receive SNAP, TANF or do not participate in an eligible Federal or State program benefits for the participant, you must provide:

Names of all household members
MONTHLY household income for each household member
Total number in household.
Total Gross Income of all Household Members.
Signature and last 4 digits of the social security number of the Adult Household Member signing the application or indicate that the adult does not possess a social security number.
Print name of Adult Household Member signing the application.
Date and Telephone Numbers of the Adult Household Member signing the application.

ELIGIBILITY INCOME SCALE
Effective from July 1, 2024 to June 30, 2025
(*As announced by the United States Department of Agriculture*)
SCALE IS BASED ON GROSS INCOME BEFORE DEDUCTION

HOUSEHOLD SIZE	REDUCED SCALE		
	ANNUAL	MONTHLY	WEEKLY
1	$19,579 - $27,861	$1,633 - $2,322	$ 378 - $ 536
2	$26,573 - $37,814	$2,216 - $3,152	$ 512 - $ 728
3	$33,567 - $47,767	$2,799 - $3,981	$ 647 - $ 919
4	$40,561 - $57,720	$3,381 - $4,810	$ 781 - $1,110
5	$47,555 - $67,673	$3,964 - $5,640	$ 916 - $1,302
6	$54,549 - $77,626	$4,547 - $6,469	$1, 050 - $1,493
7	$61,543 - $87,579	$5,130 - $7,299	$1,185 - $1,685
8	$68,537 - $97,532	$5,713 - $8,128	$1,319 - $1,876
Each Additional Family Member	**+9,953**	**+830**	**+192**

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identify and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g. Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by: 1. ***mail:*** *U.S. D epartment of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250 -9410; or 2.* ***fax*** *202 (833) 256-1665 or (202)-690-7442; or 3.* ***email:*** *program.intake@usda.gov*

This institution is an equal opportunity provider.

_____ _____

Signature of Day Care Sponsor Representative *Phone Number*
New Jersey Department of Agriculture Child and Adult Care Food Program *Phone Number 609-984-1250*

_____

Name of Sponsoring Organization
New Jersey Department of Agriculture Child and Adult Care Food Program