023 CHILD AND ADULT CARE FOOD PROGRAM ELIGIBILITY APPLICATION

NAME(S) & AGE(S) OF ENROLLED PARTICIPANT:

(Name) (Age)

OPTIONAL: RACIAL/ETHNIC IDENTITY OF PARTICIPANT

Check one ETHNIC identity:

[ ] Hispanic or Latino [ ] Not Hispanic or Latino

Mark one or more RACIAL identity (ies):

[ ] American Indian or Alaska Native [ ] Asian [ ] Black or African American

[ ] Native Hawaiian or Other Pacific Islander [ ] 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: ☐ **Mon** ☐ **Tues** ☐ **Wed** ☐ **Thus** ☐ **Fri** ☐ **Sat** ☐ **Sun**

HOURS OF CARE: **10:15 AM - 1:15 PM I 10:15 AM - 1:15 PM I 10:15 AM - 1:15 PM**

Swing/Rotating Shifts:(IfApplicable)

MEAL TYPES SERVED: ☐ **BREAKFAST** ☐ **A.M. SUPPLEMENT** ☐ **LUNCH** ☐ **P.M. SUPPLEMENT** ☐ **DINNER**

CHILD DAY CARE FOOD PROGRAM PARTICIPANTS ONLY

OPTION 1A: BENEFICIARIES of Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR)
If you are now receiving SNAP,TANF or FDPIR for this child, complete one of the following numbers:

SNAP CASE # _____ **OR TANF CASE #** _____ **OR FDPIR CASE #** _____

OPTION B: 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 ☐ **INCOME $** _____

ADULT DAY CARE FOOD PROGRAM PARTICIPANTS ONLY

OPTION 2: BENEFICIARIES of SNAP, FDPIR, SSI or Medicaid

If you are now receiving SNAP, SSI, FDPIR or Medicaid complete one of the following numbers:

SNAP# _____ **OR FDPIR CASE#** _____ **OR SSI CASE#** _____ **OR MEDICAID CASE#** _____

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.

NAMES OF ALL OTHER HOUSEHOLD MEMBERS: (Related and Unrelated)	**MONTHLY INCOME (Complete One Or More –** Before Deductions**)**				
	MONTHLYM (Gross Earnings) WAGES / SALARY	**MONTHLY SOCIAL SECURITY PENSIONS RETIREMENT**	**MONTHLY UNEMPLOYMENT WORKMEN'S COMPENSATION**	**MONTHLY WELFARE CHILD SUPPORT ALIMONY**	**MONTHLY ANY OTHER INCOME**
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$

TOTAL NUMBER IN HOUSEHOLD (INCLUDE ENROLLED PARTICIPANT): _____

TOTAL GROSS HOUSEHOLD INCOME: _____ **$** _____

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: A

City: **State:**

Date:

Zip Code:

Last four (4) digits of Social Security Number:

Phone 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 house hold member signing the application or indicate that the house hold 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.

TO BE COMPLETED BY DAY CARE AGENCY ONLY - DO NOT WRITE BELOW THIS LINE

Determination: Free

Signature of Determining Official:

Date:

Name of Determining official:

TOTAL MONTHLY INCOME $ 0.00

Conversion factors to figure monthly income: Weekly x 4.33

Twice a month x 2

Every 2 weeks x 2.15

2022-2023 CHILD AND ADULT CARE FOOD PROGRAM
LETTER OF PARENT/PARTICIPANT

Dear Parent Participant:

Our agency depends on Child and Adult C are Food Program funds to provide meals at no separate charge to all participants. C omplete information is necessary in order to receive the maximum funds available through the United States Department of Agriculture. The information will serve as documentation that our enrolled participants are eligible for the Child and Adult C are Food Program. You may complete and submit one CACFP eligibility application for all participants from the same household that are enrolled for care with our agency.

Household members include everyone in your household (such as grandparents. other relatives, or friends who live with you) who share income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you. Once properly categori:ed for free or reduced price benefits, whether through income or by providing a current SNAP, FDPIR, or TANF case number (SNAP, FDPIR. 551, or Medicaid case number for Adult Day Care Participants), you will remain eligible for those benefits for l 2 months. You should notify us. however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within those eligibility standards;

The income that you report must be the total gross income received by all members of your household.

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-pricea' standards, the participant is eligible for free or reduced-price meals from the C hila' and Adult Care Food Program, which means increased reimbursement for our centre and increased nutritional benefits for the participant.

Please complete, sign and return the form so that our centre may receive maximum reimbursement. We cannot approve a form that is not complete. so be sure to read the instructions carefully and fill out all required information. This form will be placed in our files and treated as confidential information.)our cooperation is vital and appreciated.

In accordance with Federal civil rights law and US. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees. and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age. or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA

Persons with disabilities who require alternative means of communication for program information (eg. Braille. large print, audiotape, American Sign Language, etc). should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 8 7 7-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http: www.ascr.usda.gov complain tiling cust.l1tml. and at any USDA office. To request a copy of the complaint form, call (866) 632-9992. If you have questions about any of USDA 's nutrition assistance programs, check the information on the FNS web site, http: www.fnsusdagov and. USDA is an equal opportunity provider and employer.

ADCC 2
(Day Care Center Name) **(Name & Signature of Day Care Center Representative)**

TO APPLY, YOU MUST COMPLETE ONE OF THREE OPTIONS.

1. List the Name of the participant (First and Last Names).
2. Complete the Days, Hours of Care, and the meals types served to the enrolled participant. (One time requirement for Adult Day Care participants)

Option 1A or 1B CHILD CARE PARTICIPANTS ONLY:

If you receive SNAP, TANF, or FDPIR benefits for the panicipant. list the SNAP. TANF or FDPIR Case Number and Sign and Date the form. If you are applying for Foster Child who is under the legal responsibility of the welfare agency or court, Check the Box and Sign and Date the form.

A FOSTER CHILD'S PERSONAL USE INCOME is defined as follows:
a) Funds received from a welfare agency, which can be identmed 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, eta, only those funds that can be identified as personal use funds shall be considered as income.
b) 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, babysitting).

Option 2 ADULT CARE PARTICIPANTS ONLY:

If you receive SNAP, FDPIR, SSI or Medicaid benefits for the participant, indicate the SNAP. FDPIR, SSI or Medicaid Case Number and Sign and Date the form.

Option 3 CHILD CARE AND ADULT PARTICIPANTS:

If you do not receive SNAP. TANF, FDPIR, SSI or Medicaid benetits for the participant, you must complete:
3. Names of all (Related or Unrelated) household members
4. List the household income (Monthly Gross Earnings) for each household member
5. Total number in household (#1 + #3 above).
6. Total the gross income of all household members.
7. Sign, Print and complete the full address of the Adult Household Member signing the application.
8. Date the form and complete the telephone number of Adult Household Member signing the application.
9. List the last four (4) digits of the social security number for the Adult Household Member signing the application. o_r indicate that the Adult Household Member signing the application does not possess a social security number.

ELIGIBILITY INCOME SCALE
Effective from July 1, 2022 to June 30, 2023

HOUSEHOLD SIZE	REDUCED		
	ANNUAL	MONTHLY	WEEKLY
1.	$16,745 - $23,828	$1,397 - $1,986	$ 323 - $ 459
2.	$22,647 - $32,227	$1,889 - $2,686	$ 437 - $ 620
3.	$28,549 - $40,626	$2,380 - $3,386	$ 550 - $ 782
4.	$34,451 - $49,025	$2,872 - $4,086	$ 664 - $ 943
5.	$40,353 - $57,424	$3,364 - $4,786	$ 777 - $1,105
6.	$46,255 - $65,823	$3,856 - $5,486	$ 891 - $1,266
7.	$52,157 - $74,222	$4,348 - $6,186	$1,004 - $1,428
8.	$58,059 - $82,621	$4,840 - $6,886	$1,118 - $1,589
Each Additional Family Member	**+8,399**	**+700**	**+162**