2017 CHILD AND ADULT CARE FOOD PROGRAM
ELIGIBILITY APPLICATION

NAME(S) & AGE(S) OF ENROLLED PARTICIPANT _____ _____; _____ _____
(Name) (Age) (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*	☐ *THURS*	☐ *FRI*	☐ *SAT*	☐ *SUN*
HOURS OF CARE:	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___
Swing / Rotating Shifts: (If Applicable)	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___

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 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 ☐ **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)*				
	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:					

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: * * * - * * * - ____ ____ ____ ____ ☐ **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.

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