

Child and Adult Care Food Program FAMILY DAY CARE 2021 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 [] ^ 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 FDCFP INCOME 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: <i>(Do Not Include Foster Children)</i>	MONTHLY INCOME (Before Deductions)			COMPLETE ONE OR MORE	
	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.	\$	\$	\$	\$	\$

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 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: _____
(Signature Of Adult Household Member)

(Print Name Of Adult Household Member)

_____ (Household Address)
 _____ (Household Address)

Last four (4) digits of Social Security Number: __ __ __ __ - __ __ __ - _____
 _____ (Date Signed) _____ (Home Telephone) _____ (Work Telephone)

I do not have a Social Security Number

Race/Ethnic Identity: _____

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 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 (School Data) B (Census) C (Income Data)
 TIER II: L (Low Rates) M (Mixed Rates)

Name of Determining Official: _____ / _____ / _____
 _____ (Date)