

2027 NEW JERSEY CHILD AND ADULT CARE FOOD PROGRAM
ELIGIBILITY APPLICATION

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

(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 (Gross Earnings) Wages/Salary

MONTHLY SOCIAL SECURITY PENSIONS RETIREMENT

MONTHLY UNEMPLOYMENT WORKER'S COMPENSATION

MONTHLY WELFARE CHILD SUPPORT ALIMONY

Monthly Any Others 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 a 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 the 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, and investigations and may include contacting employers to determine income, contacting 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 the form.

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

CACFP/Elig, App 6/1/2026

Dear Parent/Participant:

Our agency depends on Child and Adult Care Food Program funds to provide meals at no separate charge to all participants. Complete 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 Care 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 categorized for free or reduced price benefits, whether through income or by providing a current SNAP, FDPIR, or TANF case number (SNAP, FDPIR, SSI, or Medicaid case number for Adult Day Care Participants), you will remain eligible for those benefits for 12 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- priced s t a n d a r d s , the participant is eligible for free or reduced-price meals from the Child and Adult Care Food Program, which means increased reimbursement for our center and increased nutritional benefits for the participant.

Please complete, sign and return the form so that our center 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. Your cooperation is vital and appreciated.

In accordance with Federal civil rights law and U.S. 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, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the State or local Agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at [How to File a Program Discrimination Complaint](#) and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail; U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Mail Stop 9410, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

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TO APPLY, YOU MUST COMPLETE ONE OF THREE OPTIONS.

- List the Name of the participant (First and Last Names).
- Complete the Days, Hours of Care, and the meal 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 participant, list the SNAP, TANF or FDPIR Case Number and Sign and Date the form.

If you are applying for a 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:

- 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 the 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.
- 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 – 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 benefits for the participant, you must complete:

- Names of all (Related or Unrelated) household members
- List the household income (Monthly Gross Earnings) for each household member.
- Total number in household (1 #3 above).
- Total the gross income of all household members.
- Sign, Print and complete the full address of the Adult Household Member signing the application.
- Date the form and complete the telephone number of Adult Household Member signing the application.
- List the last four (4) digits of the social security number for the Adult Household Member signing the application or indicate that the Adult Household Member signing the application does not possess a social security number.

ELIGIBILITY INCOME SCALE - Effective From July 1, 2026 to June 30, 2027

HOUSEHOLD SIZE	REDUCED		
	ANNUAL	MONTHLY	WEEKLY
1	\$20,749 - \$29,526	\$1,730 - \$2,461	\$ 400 - \$ 568
2	\$28,133 - \$40,034	\$2,346 - \$3,337	\$ 542 \$ 770
3	\$35,517 - \$50,542	\$2,961 - \$4,212	\$ 684 - \$ 972
4	\$42,901 - \$61,050	\$3,576 - \$5,088	\$ 826 - \$1,175
5	\$50,285 - \$71,558	\$4,192 - \$5,964	\$ 968 - \$1,377
6	\$57,669 - \$82,066	\$4,807 - \$6,839	\$1,110 - \$1,579
7	\$65,053 - \$92,574	\$5,422 - \$7,715	\$1,252 - \$1,781
8	\$72,437 - \$103,082	\$6,038 - \$8,591	\$1,394 - \$1,983
Each Additional Family Member	+10,508	+876	+203