

## Child and Adult Care Food Program ENROLLMENT/INCOME-ELIGIBILITY APPLICATION

| PART 1 – CHILDREN’S INFORMATION—Required for all children in care. |           |     |  |  |                      |                     |
|--|-----------|-----|--|--|----------------------|---------------------|
| Child’s Name   | Birthdate | Age | Circle Normal Days/<br>Print Normal Hours of Care        | Circle Meals and<br>Snacks Normally Received |                      |                     |
|  |           |     | Sun Mon Tu Wed Th Fri Sat<br>Normal Hours _____ to _____ | Breakfast<br>P.M. Snack                      | A.M. Snack<br>Supper | Lunch<br>Eve. Snack |
|  |           |     | Sun Mon Tu Wed Th Fri Sat<br>Normal Hours _____ to _____ | Breakfast<br>P.M. Snack                      | A.M. Snack<br>Supper | Lunch<br>Eve. Snack |
|  |           |     | Sun Mon Tu Wed Th Fri Sat<br>Normal Hours _____ to _____ | Breakfast<br>P.M. Snack                      | A.M. Snack<br>Supper | Lunch<br>Eve. Snack |
|  |           |     | Sun Mon Tu Wed Th Fri Sat<br>Normal Hours _____ to _____ | Breakfast<br>P.M. Snack                      | A.M. Snack<br>Supper | Lunch<br>Eve. Snack |

### INCOME ELIGIBILITY

**Please check the boxes that apply to help determine the other parts of this form to complete:**

- A family member in our household receives benefits from Basic Food, TANF, or FDIPIR. (Please complete Part 2 and 5.)
- One or more of the children in Part 1 is a foster child. (Please complete Part 3 and 5.)
- My child(ren) may qualify for Free/Reduced-Price meals based on household income. (Please complete Part 4 and 5.)
- My child(ren) will not qualify for Free/Reduced-Price meals. (Please complete Part 5 only.)

| PART 2 – HOUSEHOLD MEMBER RECEIVING BASIC FOOD/TANF/FDIPIR—<br>Any household member receiving benefits can establish eligibility for all children in the household. | Case Number or Identification Number |
|---|--------------------------------------|
|   |                                      |

| PART 3 – FOSTER CHILDREN—List the names of any children listed in Part 1 who are foster children. |  |
|---|--|
|   |  |
|   |  |

| PART 4 – TOTAL HOUSEHOLD GROSS INCOME FROM LAST MONTH—Not required if you have reported a case number in Part 2. |                                      |                          |                          |                          |                          |                                 |                          |                          |                          |                          |  |                          |                          |                          |                          |
|--|--------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------|--------------------------|
| Tell us how much and how often. If no income, write "0". Use net income if self-employed.                        |                                      |                          |                          |                          |                          |                                 |                          |                          |                          |                          |  |                          |                          |                          |                          |
| List names (First and Last) of everyone in your household, including foster children                             | Earnings from Work Before Deductions | Weekly                   | Every 2 Weeks            | 2X Month                 | Monthly                  | Welfare, Alimony, Child Support | Weekly                   | Every 2 Weeks            | 2X Month                 | Monthly                  | Retirement, Pensions, Social Security, Other | Weekly                   | Every 2 Weeks            | 2X Month                 | Monthly                  |
|  |                                      |                          |                          |                          |                          |                                 |                          |                          |                          |                          |  |                          |                          |                          |                          |
| 1.   | \$                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | \$                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | \$   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2.   | \$                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | \$                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | \$   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.   | \$                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | \$                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | \$   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.   | \$                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | \$                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | \$   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5.   | \$                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | \$                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | \$   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6.   | \$                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | \$                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | \$   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| PART 5 – SIGNATURE AND CERTIFICATION—REQUIRED  |                                  |   |
|--|----------------------------------|---|
| <p>The adult household member who fills out the application must sign below. If Part 4 is completed, the adult signing the form must also list the last four digits of his/her Social Security Number (SSN) or check the box if no SSN. See Privacy Act Statement on the back of this page.</p> <p><b>If you have listed a case number in Part 2 or are applying on behalf of a foster child, or have checked the box that your child(ren) will not qualify for Free/Reduced-Price meals, the last four digits of the SSN is not needed.</b></p> <p>"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."</p> |                                  |   |
| Signature of Adult<br><br>X _____  | Today's Date<br><br>_____        | Print Name of Adult Signing<br><br>_____<br><br>Social Security Number (SSN) (last four digits)<br>XXX-XX- _____ <input type="checkbox"/> Check if no SSN |
| Address<br><br>_____   | City/State/Zip Code<br><br>_____ | Daytime Phone<br><br>_____  |

| PART 6 – CHILDREN’S ETHNIC AND RACIAL IDENTITIES (OPTIONAL) |
|---|
|---|

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one):  Hispanic or Latino  Not Hispanic or Latino

Race (check one or more):  American Indian or Alaskan Native  Asian  Black or African American  Multi-Racial  
 Native Hawaiian or Pacific Islander  White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Basic Food, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

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, 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 (e.g. 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) 877-8339. 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/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), 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:

**MAIL\*:** U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue SW  
Washington, D.C. 20250-9410

**FAX:** 202-690-7442  
**EMAIL:** [program.intake@usda.gov](mailto:program.intake@usda.gov)

**\*Only use this address if you are filing a complaint of discrimination.**

**This institution is an equal opportunity provider.**

**DO NOT FILL OUT - CENTER USE ONLY**

- Child(ren) are categorically free based on Basic Food/TANF/FDPIR.
- Foster child(ren) have been identified on this form and qualify for the free category.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

- Child(ren) on this form who are not categorically eligible qualify as follows:  
Check one:  Free  
 Reduced-Price  
 Above-Scale

Total Income: \$ \_\_\_\_\_  
 Annual  Monthly  Twice Per Month  
 Every Two Weeks  Weekly

X \_\_\_\_\_ **Signature of**  
**Institution's Representative** **Today's Date**

**NOT VALID WITHOUT SIGNATURE AND DATE.**

**EIEA Effective Date: If the institution is using the parent/guardian signature date as the effective date, the form must have been signed by the institution representative within the same month the parent signed the form or the immediately following month. If the institution representative does not evaluate and sign the EIEA within these guidelines, the institution representative's signature date must be used as the effective date.**