

Dropped Date: _____ Re-Entered Date: _____ Transferred Date: _____

CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

MEAL BENEFIT INCOME ELIGIBILITY FORM

FREE AND REDUCED PRICE MEAL (FRPM) APPLICATION FORM (October 1, 2013 – September 30, 2014)

INSTITUTION NAME: _____ FACILITY NAME: _____

PART 1. CHILD OR ADULT ENROLLED TO RECEIVE DAY CARE (USE A SEPARATE APPLICATION FOR EACH PARTICIPANT)

Print Name of Participant:	(First, Middle Initial, Last)		Age	DOB (mm/dd/yy)
Foster Child?	Yes _____	No: _____	If participant is in Foster Care, Eligibility is FREE . Enter Foster Child's Personal Income Earned in Part 2, Section 4 (If applicable)	
Enter SNAP (Food Stamp) # for Child or Adult Care, if applicable :	-z-			
Enter FITAP or FDPIR # for Child or Adult Care, if applicable:				
Enter SSI/Medicaid # for Adult Day Care Only				

PART 2. Total Household Gross Income
If you listed a SNAP/FITAP/FDPIR/SSI/Medicaid case # above, Eligibility is FREE (Skip PART 2.)

A. Name (List everyone in household, including child listed above)	B. Gross income and how often it was received Examples: \$100 / monthly \$100 / twice a month \$100 / every two weeks \$100 / weekly				C. Check if NO income
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Social Security, pensions, retirement	4. All Other Income	
	\$ /	\$ /	\$ /	\$ /	<input type="checkbox"/>
	\$ /	\$ /	\$ /	\$ /	<input type="checkbox"/>
	\$ /	\$ /	\$ /	\$ /	<input type="checkbox"/>
	\$ /	\$ /	\$ /	\$ /	<input type="checkbox"/>
	\$ /	\$ /	\$ /	\$ /	<input type="checkbox"/>
	\$ /	\$ /	\$ /	\$ /	<input type="checkbox"/>

PART 3: USDA Supplemental Annual Enrollment Information: (This section must be completed annually by an adult household member for all children enrolled at Child Care Centers participating in the USDA Child and Adult Care Food Program.)

Expected Days of participation: _____ Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday

Expected Hours of participation: From _____ To _____ or Before School: From _____ To _____ Afterschool: From _____ To _____

Expected Meal participation: _____ Breakfast _____ Lunch _____ Snack

PART 4. Adult Signature, Social Security Number, and Contact Information

An adult household member must sign this form. If Part 3 is completed, the adult signing the form must also list his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on page 2.)

I certify that all information on this form is true and that all income is reported. I understand that the center will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign Here: _____ Print Name: _____ Date: _____

Address: _____ Phone Number: _____

Social Security Number: XXX -XX - _____ I do not have a Social Security Number

Part 5. Participant's ethnic and racial identities (optional)

Mark one ethnic identity: Hispanic or Latino Not Hispanic or Latino Mark one or more racial identities: Asian White Black or African American American Indian or Alaskan Native Native Hawaiian or Other Pacific Islander

For Official Use Only: Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: Month, Twice a month, Every two weeks, Week, Year Household size: _____

Eligibility Determination: _____ Free SNAP (Food Stamp)/FITAP/FDPIR/SSI/Medicaid Eligible _____ Reduced _____ Above/ Paid

Extended Categorical Eligibility Validation Attached _____ YES _____ NO

Determining Official's Signature: _____ **Date:** _____

The Sponsor/Institution Determining Official will utilize the CACFP 108 (Standards of Eligibility) to confirm participant's eligibility status as Free, Reduced, or Above.

Effective July 1, 2013 to June 30, 2014

Family-Size Income Levels For Reduced Price Meal Eligibility Only Are:						
Households with incomes less than or equal to these levels are eligible for free or reduced price meals.	Household Size	Yearly	Monthly	Twice Per Month	Every Two Weeks	Weekly
	1	\$21,257	\$1,772	\$886	\$818	\$409
	2	\$28,694	\$2,392	\$1,196	\$1,104	\$552
	3	\$36,131	\$3,011	\$1,506	\$1,390	\$695
	4	\$43,568	\$3,631	\$1,816	\$1,676	\$838
	5	\$51,005	\$4,251	\$2,126	\$1,962	\$981
	6	\$58,442	\$4,871	\$2,436	\$2,248	\$1,124
	7	\$65,879	\$5,490	\$2,745	\$2,534	\$1,267
	8	\$73,316	\$6,110	\$3,055	\$2,820	\$1,410
	Each additional family member	+ \$7,437	+ \$620	+ \$310	+ \$287	+ \$144

Privacy Act Statement: This explains how we will use the information you give us.

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, we cannot approve your child for free or reduced price meals. 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 Supplemental Nutrition Assistance Program (SNAP), 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 if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. 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.

Nondiscrimination Statement: This explains what to do if you believe you have been treated unfairly. The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866)-632-9992 to request the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S. W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

USDA is an equal opportunity provider and employer.

INSTRUCTIONS FOR THE FREE/REDUCED PRICE MEAL (FRPM) APPLICATION FORM

If your household receives SNAP, FITAP, FDPIR, or SSI/Medicaid, follow these instructions:

- Part 1: Child Care Center:** List participant's complete legal name, age and date of birth (DOB). Indicate SNAP, FITAP or FDPIR case number, if applicable.
Adult Day Health Care (ADHC): List participant's complete name and DOB. Indicate a SNAP, FITAP, FDPIR, or SSI/Medicaid case number, if applicable.
- Part 2:** Skip this part.
- Part 3:** An adult household member must indicate normal days/hours of care and meal types for the enrolled child.
- Part 4:** An Adult must Sign, enter the last 4 digits of their Social Security Number or mark the box if there is no SSN, date, and complete the contact information.
- Part 5:** Answering this question is optional.

If you are applying on behalf of a FOSTER CHILD, follow these instructions:

- Part 1:** Enter the child's name, age, and DOB.
Check "Yes"
- Part 2:** **NOTE:** A Foster Child is the legal responsibility of a welfare agency or court. Eligibility is categorically Free. If the Foster Child receives "**personal earned income**" enter that amount in Part 2, section 4. Income received by the placing agency should not be included as income.
- Part 3:** An adult household member must indicate normal days/hours of care and meal types for the enrolled child. (**Days, hours, and meal types may vary based on actual participation**)
- Part 4:** Sign the form. A Social Security Number is **not** necessary.
- Part 5:** Answering this question is optional.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

- Part 1: Child Care Center:** List participant's complete legal name, age, and DOB. Indicate SNAP, FITAP or FDPIR case number, if applicable.
Adult Day Health Care (ADHC): List participant's complete name, age, and DOB. Indicate a SNAP, FITAP, FDPIR, or SSI/Medicaid case number, if applicable.
- Part 2:** Follow these instructions to report total household income from last month.
Column A–Name: List first and last name of **each** person living in the household, related or not, such as, grandparents, other relatives, or friends, including yourself, the applicant and all other children.
Column B–Gross income last month and how often it was received. Next to each person's name, list each type of income received last month, and how often it was received.
In Box 1, list **gross income** each person earned from work. This is not the same as take-home pay. **Gross income is the amount earned before taxes and other deductions.** Next to the amount each person received, write how often; for example: weekly, every other week, twice a month, or monthly.
In box 2, list amount each person received last month from welfare, child support, or alimony.
In box 3, list Social Security, pensions, and retirement.
In box 4, list **ALL OTHER INCOME SOURCES:** Personal earned income by a Foster Child, Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits, regular contributions from people not in your household. Report net income of self-owned business, farm, or rental income. Next to the amount each person received, write how often. Participants of the Military Housing Privatization Initiative should not include housing allowance.
Column C–Check if no income: If the person does not have any income, check the box.
- Part 3:** An adult household member must indicate normal days/hours of care and meal types for the enrolled child.
ADHC: SSI/Medicaid recipients skip this part.
- Part 4:** An Adult household member must sign, enter the last 4 digits of their Social Security Number, date, and complete the contact information or mark the box if there is no SSN. Adult Day Care participants, who are unable to sign, may indicate their "**MARK**" as signature with a witness.
- Part 5:** Answer this question if you choose to.