



Child and Adult Care Food Program INCOME ELIGIBILITY APPLICATION

Name of Center	Provider ID #:	Phone Number () /
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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, 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 Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

Instructions: Complete this form and return to the Center's Office

(Check if applicable for Enrolled Participant)

ENROLLED PARTICIPANT INFORMATION: Case #:

First:	Last:	DOB:	Child Care Centers:	Adult Daycare Centers:
_____	_____	_____	<input type="checkbox"/> Foster Child? <input type="checkbox"/> SNAP <input type="checkbox"/> FDPIR	<input type="checkbox"/> SNAP <input type="checkbox"/> FDPIR <input type="checkbox"/> SSI <input type="checkbox"/> MED
_____	_____	_____	<input type="checkbox"/> Foster Child? <input type="checkbox"/> SNAP <input type="checkbox"/> FDPIR	<input type="checkbox"/> SNAP <input type="checkbox"/> FDPIR <input type="checkbox"/> SSI <input type="checkbox"/> MED
_____	_____	_____	<input type="checkbox"/> Foster Child? <input type="checkbox"/> SNAP <input type="checkbox"/> FDPIR	<input type="checkbox"/> SNAP <input type="checkbox"/> FDPIR <input type="checkbox"/> SSI <input type="checkbox"/> MED
_____	_____	_____	<input type="checkbox"/> Foster Child? <input type="checkbox"/> SNAP <input type="checkbox"/> FDPIR	<input type="checkbox"/> SNAP <input type="checkbox"/> FDPIR <input type="checkbox"/> SSI <input type="checkbox"/> MED

If Enrolled Participant is a Foster Child: Please list the amount of the child's "personal use" monthly income (if no personal income, record "0"): _____

HOUSEHOLD INFORMATION:

List the first and last name of each person living in the household, related or not (such as grandparents, other relatives, or friends who live in the household). Include yourself and all children over the age of 13 living with you. (Please use additional forms if more lines are required).

First: _____	Last: _____	First: _____	Last: _____
_____	_____	_____	_____
_____	_____	_____	_____

Total Number in Household: _____

HOUSEHOLD INCOME: (Please indicate source and amount of current income for all members of your household. Please follow the definition of income specified in the standards for determining free and reduced-price eligibility in your parent letter. If you receive more than one check from any of these sources, please indicate the total *monthly* amount received.

Wages / Salary: \$ _____ Child Support: \$ _____ Social Security: \$ _____ Pension/Retirement: \$ _____
 Unemployment: \$ _____ Other Income: \$ _____ **Total Income:** \$ _____ Monthly

PENALTIES FOR MISREPRESENTATION: I certify that all the above information is true and correct and that the food stamp or FDPIR number is correct or that all income is reported. I understand that this information is being given for the receipt of Federal funds; that institution officials may verify the information on the statement and the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

 Signature of Adult Family Member Last Four Digits of Social Security Number* Check if no SS# Date

Privacy Act Statement:

This explains how we will use the information you give us. The Richard B. Russell National School Lunch Act requires that, unless the participant's food stamp or FDPIR number is provided, you must include the social security number of the household member signing the statement or an indication that the household member signing the statement does not possess a social security number. Provision of a social security number is not mandatory, but if a social security number is not provided or an indication is not made that the adult household member signing the statement does not have one, the statement cannot be approved. The social security number may be used to identify the household member in carrying out efforts to verify the correctness of the information on the statement. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a food stamp or FDPIR office to determine current certification for receipt of SNAP (food stamp) or FDPIR benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to verify the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal action if incorrect information is reported.

FOR SPONSOR'S USE ONLY

Child Day Care Center Adult Day Care Center Approved Free Approved Reduced Paid

_____ Signature of Center Representative	_____ Name of Center Representative	_____ Approving Date	_____ Date Disenrolled
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* Complete Social Security Number is not required for CACFP Participation, only the last four digits are required.