CACFP Application for Free and Reduced Price Meals (Child Care)

Sponsor Name:	**Phone Number:**
Center:	**FDC Provider:**

Part 1. All Household Members

Names of all household (First, Middle Initial, Last)	Birth Dates of Children	Check if a foster child (the legal responsibility of a welfare agency or court) * If all children listed below are foster children, skip to Part 4 to sign this form.	Check if NO income
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

Part 2. Benefits: If any member of your household received [Food Stamps] or [State TANF cash assistance], provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to Part 3.**

Name:_____ Case number: _____

Part 3. If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call [Insert center contact and phone number] Homeless ❑ Migrant ❑ Runaway❑

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List **only** household members with income)	**B. Gross income and how often it was received** 1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All other income
(Example) Jane Smith	$200/weekly	$150/twice a month	$100/monthly	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home 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: _____

City:_____ State: _____ Zip Code: _____

Last four digits of Social Security Number: XXX - XX - __ __ __ __ ❑ I do not have a Social Security Number

_____ Initial here if you consent to allow [Provider's Name] to collect your form and provide it to the Sponsor. [Provider's Name] will not review your form.

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A child enrolled in the day care facility may qualify for free or reduced price meals if the household income falls at or below the limits on this chart:

July 1, 2014 to June 30, 2015			
Household Size	Monthly Income	Household Size	Monthly Income
1	1,800	5	4,303
2	2,426	6	4,929
3	3,051	7	5,555
4	3,677	8	6,181
For each additional family member, add $626			

Part 6. Participant's Ethnic and Racial Identities (Optional)

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

Part 7: Other Benefits: The law allows us to tell Medicaid and Hoosier Healthwise that your children are eligible for free or reduced-price meals. We may share your application information with Medicaid or Hoosier Healthwise unless you do not want us to. If you DO NOT want us to share this information, sign here:

_____ For information about Hoosier Healthwise health insurance

Signature of Parent or Legal Guardian Call **1-800-889-9949**

Privacy Act Statement: 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 the participant 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 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 for the participant or other (FDPIR) identifier 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 the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

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. You may also write a letter containing all of the information requested in 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.

Child Care Representative Use Only

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

Section A *Mark one of the boxes below to show how you are going to determine eligibility.*

❑ **Food Stamp or TANF Household**—the Food Stamp or TANF number meets the criteria for an acceptable case number.
Complete Section B & C **OR**

❑ **Foster Child**—Compare the foster child's personal income to the guidelines.
Complete Section B & C **OR**

❑ **Household Income**—Complete the information below and Complete Section B & C

Total Household Size: _____

Total Household Income $_____/_____
Example: $100/week

Compare total household income to current USDA Income

Section B

Based on the information provided, this application will be:

❑ Approved Free ❑ Approved Tier I
❑ Approved Reduced ❑ Approved Tier II
❑ Paid

Use this space for income calculation.

Section C

_____
Signature of Sponsor Representative

_____

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Eligibility Guidelines. When the household incomes are listed for different pay periods, you must convert all income to monthly or annual income. Use the conversion listed above.	Date of Approval **THIS FORM EXPIRES ONE YEAR FROM THE DATE IT WAS APPROVED**