North Carolina
Department of Health and Human Services
Women's and Children's Health
CHILD AND ADULT CARE FOOD PROGRAM
ADULT ELIGIBILITY APPLICATION

To apply for free and reduced-price meals, carefully complete, sign, date, and return this application to:

_____. If you have questions about this form, please call (_____)_____
Name of Institution Telephone #

1. PRINT PARTICIPANT NAME AND DATE OF BIRTH: _____
First Name Last Name Date of Birth

2. MEDICAID, SSI, FDPIR AND/OR SNAP HOUSEHOLDS: If the applicant is currently included in a Medicaid, SSI FDPIR and/or SNAP program, you may give the case number instead of listing income. ☐ Yes, we receive Medicaid, SSI, FDPIR and/or SNAP. If an adult participant is a member of a SNAP or FDPIR household or is a SSI or Medicaid participant, the adult participant is automatically eligible to receive free Program meal benefits, subject to the completion of the application.
Medicaid# _____ **SNAP #** _____
SSI# _____ **FDPIR ID#** _____

If yes, and you have provided the case number, **do not complete #3. Complete #4** (voluntary) and **#5**.

3. HOUSEHOLD MEMBERS AND MONTHLY INCOME: List all others living in your household, including participant listed above. List all gross income **(before deductions)** received last month. **If you did not give a Medicaid, SSI, FDPIR and/or SNAP case number, you must complete the income information.**

Names of Household Members	Monthly Wages Salaries	Monthly Social Security	Monthly Retirement Pensions Earnings	Other Monthly Earnings
	$	$	$	$
	$	$	$	$
	$	$	$	$

4. ETHNIC IDENTITY: (Please check one).
☐Hispanic or Latino ☐Not Hispanic or Latino

RACE OF PARTICIPANT: (Please check one or more).
☐ White ☐ Black or African American ☐ American Indian or Alaskan Native
☐ Asian ☐ Native Hawaiian or Other Pacific Islander

5. SIGNATURE AND LAST FOUR DIGITS OF THE SOCIAL SECURITY NUMBER: I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds; that Program officials may verify the information on the application and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal criminal laws.

_____ Last Four Digits of Social Security Number: _____
Signature of Adult Household Member (Required) Date
Last four digits of the Social Security number required for households qualifying by income

_____ _____
Printed Name Home Telephone # Work Telephone #

_____
Address

Section 9 of the National School Lunch Act requires that, unless a SNAP, or FDPIR case number or SSI or Medicaid assistance identification number is provided for the adult for whom benefits are sought, you must include the last four digits of your social security number on the application. This must be the last four digits of the social security number of the adult household member signing the application. If the adult household member signing the application does not possess a social security number, he/she must indicate so on the application. Provision of the last four digits of the social security number is not mandatory, but if the last four digits of the social security number is not provided or an indication is not made that the adult household member signing the application does not have one, the application cannot be approved. This notice must be brought to the attention of the household member whose last four digits of his/her social security number is disclosed. The last four digits of the social security number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the application. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a SNAP, Indian tribal organization or welfare office to determine current certification for receipt of SNAP or FDPIR benefits, contacting the issuing office of SSI or Medicaid benefits to determine current certification for receipt of these benefits, contacting the State employment security office to determine the amount of benefits received, and checking the documentation produced by household members to provide the amount of income received. These efforts may result in loss or reduction of benefits, administrative claims or legal action if incorrect information is reported.

For Institution Use Only

TOTAL HOUSEHOLD SIZE: _____TOTAL HOUSEHOLD MONTHLY INCOME: $_____
Approved: ☐ Free ☐ Reduced ☐ Denied
Reason for denial: ☐ Income too high ☐ Incomplete application ☐ Other

Withdrew on (Date)

For state use only:
Verified by:_____
Date:_____
Verified classification: ☐ Free ☐ Reduced ☐ Denied
Reason for change in classification:_____

_____ _____
Signature of Eligibility Official (Individual at the Institution level) Date

CAC 11A (04/15)
Nutrition Services

CACFP ELIGIBILITY APPLICATION INSTRUCTIONS

Please complete the Child and Adult Care Food Program Eligibility Applications using the instructions below. Sign the statement and return it to the adult day care center.

PART 1-PARTICIPANT'S INFORMATION: Complete this part.
Print the name(s) of the adult enrolled in the center.

PART 2-HOUSEHOLD GETTING SNAP, MEDICAID, SSI, OR FDPIR BENEFITS: Complete this PART and PART 5.
(1) List your current SNAP, Medicaid, SSI, or FDPIR case identification number.
(2) An adult household member must sign the statement in PART 5.

PART 3- HOUSEHOLD INCOME: Complete this PART and PART 5
(1) List the names of household members, including the adult enrolled in the center.
(2) Write the amount of income (the amount before taxes or anything else is taken out), the frequency of income (i.e. weekly, every two weeks, twice a month, or monthly) received **last month** for each household member and where it came from, such as earnings, welfare, pensions and other income (refer to examples below for types of income to report). If any amount last month or less than usual, write the person's usual income.
(3) An adult household member must sign this income eligibility statement and give the last four digits of his/her security number in PART 5.

PART 4-ETHNIC/RACIAL IDENTITY: Complete the Ethnic/Racial identity question.

PART 5-SIGNATURE AND LAST FOUR DIGITS OF THE SOCIAL SECURITY NUMBER:
All households complete this PART.
(1) All eligibility statements must have the signature of an adult household member;
(2) The adult household member who signs the statement must include **the last four digits** of his/her social security number. If he/she does not have a social security number, write "none". If you listed a SNAP, Medicaid, SSI, or FDIR number the last four digits of a social security number is not needed.

INCOME TO REPORT

Earnings from Employment
Wage/salaries/tips
Strike benefits

Unemployment compensation
Worker's compensation
Net income from self-owned business or farm

Welfare/Child Support/Alimony
Public assistance payments
Welfare payments
Alimony/Child support payments

Pensions/Retirement/Social Security
Pensions
Supplemental security income
Retirement income
Veteran's payments
Social security

Military Households
All cash income, including military housing/uniform allowances. Does not include "in-kind" benefits NOT paid in cash (base housing, clothing, food, medical care, etc.)

Other Income
Disability benefits
Cash withdrawn from savings
Interest/dividends
Income from estates/trusts/ investments

Regular contributions from persons not living in the household
Net royalties/annuities/ net rental income
Any other income

PARTICIPANT/GUARDIAN HOUSEHOLD LETTER FOR NON-PRICING INSTITUTIONS
CHILD AND ADULT CARE FOOD PROGRAM

Dear Participant or Guardian,

Please help us comply with the federal requirement mandating the annual submission of Program Eligibility Application (CAC 11A). This application will be used only for eligibility determination, placed in our files and treated as confidential information. In order for participants and the day care center to be considered eligible for program benefits, an adult household member must complete the Program Eligibility Application for each participant enrolled in the center as soon as possible, sign, date and return it to the day care center. Completion of the application is not mandatory for participants unless you which to be considered for eligibility as a free or reduced price participant.

SNAP, Supplemental Security Income (SSI), Medicaid, Food Distribution Program on Indian Reservations Households (FDPIR) participants: If the participant currently receive SNAP, SSI, Medicaid or FDPIR the participant is automatically eligible for free meals. You only have to list the SNAP case number, SSI, Medicaid or FDPIR identification number, sign, date and return the application.

All Other households: If the participant's household income is at or below the level shown on the enclosed scale, the participant is eligible for either free or reduced price meals. To apply for meal benefits, the following information must be provided or the application cannot be approved.

***Household Members**: List the name of the participant and the participant's spouse, and any dependent children, who live in the participant's household.
***Current Income**: List the amount of income each person received last month (BEFORE deductions for taxes, social security, etc.) Frequency of income and where it is from, such as wages, retirement, or public assistance. If any household member's income last month was higher or lower than usual, list that person's expected average monthly income.
***Signature**: an adult household member must sign the application.
***Social Security Number**: List the last four digits of the social security number of the adult who signs the application. If that adult does not have a social security number, print "None".

If you have a household member whose last month's income was higher or lower than usual, list that person's expected average monthly income.

EFFECTIVE JULY 1, 2015 - JUNE 30, 2016
REDUCED GUIDELINES

HOUSEHOLD SIZE	YEARLY	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY
1	21,775	1,815	908	838	419
2	29,471	2,456	1,228	1,134	567
3	37,167	3,098	1,549	1,430	715
4	44,863	3,739	1,870	1,726	863
5	52,559	4,380	2,190	2,022	1,011
6	60,255	5,022	2,511	2,318	1,159
7	67,951	5,663	2,832	2,614	1,307
8	75,647	6,304	3,152	2,910	1,455
For each Household member add:	+7,696	+642	+321	+296	+148

You may submit a program eligibility application any time during the fiscal year. Participants having family members who become unemployed are eligible for free or reduced-price meals during the period of unemployment, provided that the loss of income causes the family's income during the period of unemployment to be within the eligibility standards for those meals.

In accordance with Federal law and U.S. Department of Agriculture policy, this institution 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 if 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.) To file a Civil Rights 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 by mail to U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, SW, 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.