CACFP INCOME ELIGIBILITY
CHILDREN ENROLLED IN FAMILY DAY CARE HOMES

PART I
Child's Name:
Last_____First_____M.I.____Date of Birth_____
Child's Name:
Last_____First_____M.I._____Date of Birth_____
Provider's Name:

PART 2A - HOUSEHOLDS NOW GETTING SNAP, TANF/WORK FIRST, FDPIR, NATIONAL SCHOOL LUNCH OR WIC BENEFITS: Complete this part and sign the statement in PART 3 - DO NOT complete PART 2B. If a child or a child's parent is participating in or subsidized under a Federally or State supported child care or other benefit program with an income eligibility limit that does not exceed the eligibility standard for free or reduced price meals, meals served to the child are automatically eligible for tier I reimbursement, subject to the completion of the application.

SNAP case #: _____ WIC#: _____
TANF/Work First identification #: _____ Receives Free/Reduced Priced School Lunch (NSLP) ☐ (Check if applies)
FDPIR identification #: _____ Receives Free/Reduced Priced School Breakfast (SBP) ☐ (Check if applies)
(Food Distribution Program on Indian Reservations)

Federally funded Head Start Program ☐ (Check if applies)

PART 2B - ALL OTHER HOUSEHOLD MEMBERS: If you did not complete PART 2A, complete this PART and PART 3.

NAMES	CURRENT INCOME/FREQUENCY - (Last Month)			
Names of All Household Members	**Earnings from Work (Before Deductions) Job 1**	**Welfare, Child Support, Alimony**	**Payments from Pensions, Retirement, Social Security**	**Earnings from Job 2 or any Other Income**

PART 2C - Complete this PART and PART 3. If this is a foster child check here ( ). Foster children are categorically eligible for free and reduced-price meals regardless of household income. Households with foster and non-foster children may choose to include the foster child as a household member, as well as any personal income earned by the foster child, on the same household application that includes their non-foster children.

Is this a homeless child or a child evacuated from Japan or Bahrain? ☐ Yes ☐ No. Certification from the agency that assisted with the evacuation or is providing shelter is required.

PART 3 - SIGNATURE AND LAST FOUR DIGITS OF THE SOCIAL SECURITY NUMBER: **An adult household member must sign the statement before it can be approved.** 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.

Signature of Adult:_____ Last Four Digits of Social Security Number: _____
(Required) (Required (last 4 digits) for households qualifying by income)

Printed name of Adult:_____ Date Signed:_____

Home Address Zip Code Home Telephone Work Telephone

PART 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

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but it 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 your apply on behalf of a foster child or you list a SNAP, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child 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 your child is eligible for free or reduced price meals and for administration and enforcement of the Program. If a child is a Head Start participant, the child is automatically eligible to receive free Program meal benefits, subject to submission by Head Start officials of a Head Start statement of income eligibility or income eligibility documentation.

For Sponsoring Organization Use Only: Verification of SNAP, TANF or FDPIR household categorically eligible for program benefits:
MONTHLY INCOME CONVERSION: WEEKLY X 4.33 EVERY 2 WEEKS X 2.15 TWICE A MONTH X 2

Total family income:_____ Family size:

Tier I _____ Eligible:

Tier II _____ Not Eligible:

Determining Official Signature: _____ Date:

For state use only:
Verified by:_____
Date:_____
Verified classification: ☐ Free ☐ Reduced ☐ Denied

CACFP INCOME ELIGIBILITY
CHILDREN ENROLLED IN FAMILY DAY CARE HOMES

PARENT/GUARDIAN HOUSEHOLD LETTER

Dear Parent/Guardian:

Your day care provider participates in the Child and Adult Care Food Program (CACFP) funded by the U.S. Department of Agriculture and administered by the North Carolina Department of Health and Human Services. Please help us comply with the CACFP requirements by completing, signing and returning the attached income statement to the address provided. This information is necessary so that your day care provider may be paid for the meals served to the children in their care. All children in our program receive their meals free of charge, but the income eligibility category determines the amount of funding your day care provider will receive. The information you provide on this form will be confidential and will **NOT** be shared with your day care provider or anyone else without your permission.

Complete the application as follows:

- **HOUSEHOLD MEMBERS:** List the name of the enrolled child(ren), and the child's parent(s) or guardian, and any other dependent children who live in the household.
- **SNAP, TANF/WORK FIRST, FDPIR, WIC, FREE/REDUCED PRICE SCHOOL LUNCH:** If a household member is currently receiving benefits from any of these programs, provide the program case/identification number as requested. Do not complete Part 2B.
- **CURRENT INCOME:** List the amount of income each person earned **last** month **(BEFORE)** deductions for taxes, social security, etc.), the frequency of income, and where it is from, such as wages, retirement, or welfare. If any household member's income last month was higher or lower than usual, list that person's usual average monthly income.
- **SIGNATURE:** An adult household member must sign the income eligibility application.
- **Last Four Digits of the Social Security Number:** List the last four digits of the social security number of the adult who signs the income eligibility statement. If that adult does not have a social security number, print "None"

EFFECTIVE JULY 1, 2012 - JUNE 30, 2013
REDUCED GUIDELINES

HOUSEHOLD SIZE	YEARLY	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY
1	20,665	1,723	862	795	398
2	27,991	2,333	1,167	1,077	539
3	35,317	2,944	1,472	1,359	680
4	42,643	3,554	1,777	1,641	821
5	49,969	4,165	2,083	1,922	961
6	57,295	4,775	2,388	2,204	1,102
7	64,621	5,386	2,693	2,486	1,243
8	71,947	5,996	2,998	2,768	1,384
For each Household member add:	+7,326	+611	+306	+282	+141

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 is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (866) 632-9992 (Voice). Individuals who are hearing impaired 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.

There is now an affordable health insurance program for children, Health Choice, offered by the State of North Carolina. Health Choice is a comprehensive health plan which covers both hospitalization and outpatient care, including preventive dental, vision, and hearing benefits. This new health plan is intended for children whose parents' income is too high to qualify for Health Check, the state Medicaid program. Applications for Health Choice will be available beginning in October 1998. You may pick up applications from your local health or county social services departments. Get more information on either Health Choice or Health Check by calling this toll free phone number: (800) 367-2229.

CACFP INCOME ELIGIBILITY APPLICATION INSTRUCTIONS
CHILDREN ENROLLED IN FAMILY DAY CARE HOMES

PART 1 – PARTICIPANT'S INFORMATION: Complete this part.
(1)Print the name of each child enrolled in the Day Care Home.
(2) Print the name of the Day Care Home provider.

PART 2A - HOUSEHOLD GETTING SNAP, TANF/WORK FIRST, FDPIR, NATIONAL SCHOOL LUNCH, SCHOOL BREAKFAST, HEADSTART OR WIC BENEFITS:
Complete this PART and PART 3.
(1)List your current SNAP case number or your TANF/Work First, FDPIR, or WIC identification number, or check yes to indicate that your child receives free/reduced priced school lunch. Do not complete Part 2B.
(2)An adult household member must sign the statement in PART 3.

PART 2B - HOUSEHOLD INCOME: **Complete this PART and PART 3**
(1)List the names of household members.
(2)For each household member provide the gross income (the amount before taxes or any other deductions), 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 was more 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 social security number in PART 3.

INCOME TO REPORT

Earnings from Employment
Wages/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

PART 2C -FOSTER CHILD: Complete this PART and PART 3 for each foster child living in your home and enrolled in the facility. Households with foster and non-foster children may choose to include the foster child as a household member, as well as any personal income earned by the foster child, on the same household application that includes their non-foster children.

PART 3 - SIGNATURE AND LAST FOUR DIGITS OF 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, TANF/Work First, WIC, or FDPIR number a social security number is not needed.

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

The section below should be returned with the CACFP Eligibility Application if consent is given to the provider to collect this form.

Written Consent Clause: Provider's Name:_____

If you choose to complete the CACFP Eligibility Application, you have the option of returning it directly to your Provider or to the Provider's Sponsor. If you want to provide the CACFP Eligibility Application directly to the sponsor, return the competed form to:
Name and Address of Sponsoring Organization

_____ Initial here if you consent to allowing _____ to collect your form and provide it to
(Provider's Name)
the Sponsor. _____will not review your form.

(Provider's Name)