FAMILY INCOME ELIGIBILITY FORM - CHILD AND ADULT CARE FOOD PROGRAM

Dear Parent or Guardian:

Your child(ren)'s day care home participates in the Child and Adult Care Food Program (CACFP). CACFP reimburses the home provider for partial cost of serving nutritious meals to children in attendance. Participation in the CACFP helps providers to keep fees lower as well as serve nutritious meals to your child in care. The provider is paid a higher rate of reimbursement for meals served to children whose family income is at or below federal guidelines or whose family receives assistance from a state or federal program listed below.

Note: no white out or erasure should be used. If there is an error cross through, correct, and initial.

Part 1 PROVIDER AND CHILDREN:

- Print the first and last name of the provider who cares for your child(ren).
- Print first and last name and date of birth for each child enrolled in the child care home.
- Check the box if the child is a foster child (the legal responsibility of a foster care agency or the court).

Part 2 FOR A HOUSEHOLD RECEIVING BENEFITS FROM THE FOOD ASSISTANCE PROGRAM (FA), TEMPORARY ASSISTANCE FOR FAMILIES (TAF), FOOD DISTRIBUTION PROGRAM ON INDIAN RESERVATIONS (FDPIR), OR ONE OF THE OTHER FEDERAL OR STATE PROGRAM LISTED BELOW (with an income eligibility limit that does not exceed 185% of poverty):

- Complete Parts 1, 2 and 4 on the reverse side.
- Provide the name and case number for the program from which benefits are received.

Federal Programs
National School Lunch Program
Special Supplemental Nutrition Program for Women Infants and Children (WIC)
Commodity Supplemental Food Program (CSFP)
Head Start Program
Even Start Program

State Programs
Medical Assistance
Child Care Assistance
Emergency Food Assistance Program (TEFAP)
Low Income Energy Assistance Program

Part 3A FOR A HOUSEHOLD EXCEEDING THE INCOME GUIDELINES BELOW:

- Complete Parts 1, 3A and 4 on the reverse side.

TO CALCULATE ANNUAL INCOME

(W) Weekly Income X 52 ♦ (E2) Every 2 Weeks Income X 26 ♦ (2M) Twice a Month Income X 24 ♦ (M) Monthly Income X 12

Household Size:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	Each Additional Family Member
Annual Income:	$29,526	$40,034	$50,542	$61,050	$71,558	$82,066	$92,574	+ $10,508

Part 3B FOR ALL OTHER HOUSEHOLDS:

- Complete Parts 1, 3B and 4 on the reverse side using the additional information below.
- HOUSEHOLD NAMES: Write the names of everyone in your household not listed in Part 1. Include yourself and all other children, your spouse, grandparents, other relatives and unrelated people in your household. Use a separate sheet of paper if you do not have enough space.
- GROSS INCOME BEFORE DEDUCTIONS: Write the amount of income each person receives on the same line as their name. Use the appropriate column(s): Earnings from Work, Welfare/Child Support/Alimony, Pensions/Retirement/Social Security or Other Income (see list below). Next to the amount of income circle how often the income was received. Income is all money before taxes before anything else is taken out. **If a person does not have income, check the box for zero income.**
  - OTHER INCOME: strike benefits, unemployment compensation, worker's compensation, disability benefits, interest/dividends, cash withdrawn from savings, income from estates/trust/investments, royalties/annuities/rental income, and regular contributions from persons not living in the household.
  - FOSTER CHILDREN*:* List any personal income received by the foster child. Personal income is (a) money given for the child's personal use, such as clothing, school fees and allowances and (b) all other money the child gets, such as money from his/her family.
  - MILITARY HOUSING BENEFITS: Report off-base housing allowance as income. If the housing is part of the Military Housing Privatization Initiative, do not include as income.
  - SELF-EMPLOYMENT: Report income derived from the business venture less operating costs for net income. The loss from the business cannot be deducted from a positive income earned in other employment. The least possible income is zero.
- SOCIAL SECURITY NUMBER: Write the last four (4) digits of the social security number of the adult household member who signs the form. If the adult household member does not have a social security number, check the box. Use of this information is for CACFP use only and is required.

Part 4 SIGNATURE AND CONTACT INFORMATION:

- Sign and date the application.
- Complete the contact information – name, address, telephone number, and employer information.
- Initial if you give permission to the provider to collect this form and return it to the sponsor. Not initialing the form indicates that you will return the form directly back to the sponsor yourself.

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.

FAMILY INCOME ELIGIBILITY FORM
JULY 1, 2026 THROUGH JUNE 30, 2027

Part 1. PROVIDER'S NAME: _____
Last First

CHILDREN: List name(s) and birthdate(s) of your children enrolled for child care. If the child is a foster child, check the box.

Last Name	First Name	Date of Birth	Foster Child
			☐
			☐
			☐
			☐

Part 2. HOUSEHOLDS RECEIVING BENEFITS FROM THE FOOD ASSISTANCE PROGRAM (FA), TEMPORARY ASSISTANCE FOR FAMILIES (TAF) OR FOOD DISTRIBUTION PROGRAM ON INDIAN RESERVATIONS (FDPIR): Complete Parts 1, 2 and 4.

Program Name: _____ Case No. _____

If your household receives assistance from another program(s) listed on the reverse side, please list the program and case number below.

Program Name: _____ Case No. _____

Part 3A. HOUSEHOLDS EXCEEDING THE INCOME GUIDELINES: Complete Parts 1, 3A and 4.

If your family income exceeds the income guidelines (listed on the reverse side), check this box ☐

Part 3B. ALL OTHER HOUSEHOLDS – If you do not have a FA, TAF or FDPIR case number: Complete Parts 1, 3B and 4.

	GROSS INCOME BEFORE ANY DEDUCTIONS (Net for Self Employed) W = Weekly E2 = Every 2 weeks 2M = Twice a month M = Monthly Y = Yearly								
List the Names of All Household Members not listed in Part 1	**Earnings from Work**		**Welfare, Child Support, Alimony**		**Pensions, Retirement, Social Security**		**All Other Income**		**Check If ZERO income**
	How much?	How often?	How much?	How often?	How much?	How often?	How much?	How often?	
(Example) Jane Smith	*$200*	*W*	*$150*	*2M*	*$100*	*M*			
1									☐
2									☐
3									☐
4									☐
5									☐

Social Security Number of Household Member who signs form (last 4 digits only):

Social Security Number: XXX – XX – _____ If you do not have a Social Security Number, check this box ☐

Privacy Act Statement: Section 9 of the National School Lunch Act requires that, unless your children's food stamps, FDPIR or TAF case number is provided, you must include the social security number of the household member signing the form or indicate that the household member signing the form does not have 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 application does not have a social security number, the application cannot be approved. This notice must be brought to the attention of the household member whose social security number is disclosed. 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. This may include program reviews, audits, and investigations; contacting employers to determine income; contacting a food stamp or welfare office to determine current certification for receipt of food stamps, TAF 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 prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

Part 4. SIGNATURE: *I certify that 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 sponsor 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 laws. An adult must sign the application before it can be approved.*

_____ _____
Signature of Parent or Guardian Date

_____
Print Name

_____
Address

_____
City, State Zip Code

Initial here if you consent to allow your provider to collect this form and return it to the Sponsor. The Provider should not review your form. _____

If not initialed, this indicates that you will return the form directly to the Sponsor.

_____
Daytime Telephone

_____
Employer(s)

For Sponsor Use Only

☐ **FA/TAF/FDPIR** ☐ **Homeless Documentation** from school, emergency shelter, or agency

☐ **FOSTER CHILD – automatically eligible** List name of foster child(ren): _____

☐ **HOUSEHOLD INCOME: _____ HOUSEHOLD SIZE: _____**

Household Determined: ☐ **Not Eligible** ☐ **Eligible** Effective Date: _____ Expiration Date: _____

_____ _____ _____ _____
Determining Signature Date Confirming Signature Date