CACFP MEAL BENEFIT INCOME ELIGIBILITY LETTER (FAMILY DAY CARE HOME – PROVIDER)

Dear Provider:

To qualify for Tier I or Tier II reimbursement, or if you wish to receive reimbursement for meals served to your own children under the U.S. Department of Agriculture's Child and Adult Care Food Program (CACFP), you must complete the reverse side of this form, sign and return to us the Meal Benefit Income Eligibility Form.

Household size	Yearly
1	$25,142
2	$33,874
3	$42,606
4	$51,338
5	$60,070
6	$68,802
7	$77,534
8	$86,266
Each additional person:	$ 8,732

Privacy Act Statement (This explains how we will use the information you give us): 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.

Non-discrimination Statement (This explains what to do if you believe you have been treated unfairly):
In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil

Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or

2.fax:

(833) 256-1665 or (202) 690-7442; or

3. email:

program.intake@usda.gov

This institution is an equal opportunity provider.

PLEASE COMPLETE THE NEXT PAGE
Or sign Waiver below

At this time, I choose not to complete the application for consideration of Income Eligibility or to claim my own children.

_____

Signature

CHILD AND ADULT CARE FOOD PROGRAM
MEAL BENEFIT INCOME ELIGIBILITY FORM (Family Day Care Home-Provider)
FISCAL YEAR 2023

To apply for reimbursement for meals served to your own children carefully complete and return to your sponsor.

Part 1. All Household Members - including Residential Children. Request additional sheet if necessary.

Names of all household members (First, Middle Initial, Last)	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
Adult Household Member #1:	☐	☐
Adult Household Member #2:	☐	☐
Adult Household Member #3:	☐	☐
Child #1:	☐	☐
Child #2:	☐	☐
Child #3:	☐	☐
Child #4:	☐	☐

Part 2. Benefits: If any member of your household received [DES Food Stamps], [FDPIR], or [DES Cash Assistance], provide the name and case number for the person who receives benefits and skip to Part 4. **If no one receives these benefits, skip to part 3.**

NAME:_____ CASE NUMBER: ___ ___ ___ ___ ___ ___ ___ ___

Part 3. 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: identify weekly, every other week, monthly, yearly….**			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
	how much/how often	**how much/how often**	**how much/how often**	**how much/how often**
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

Part 4. Signature and Last Four Digits of Social Security Number: An adult household member must sign this form. **If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or write the word None if the signer doesn't have a Social Security Number.** (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 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: * * * - * * - ____ ____ ____ ____ If no SSN, write the word "NONE" _____

Part 5. If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call your school, homeless liaison, migrant coordinator. Homeless ❑ Migrant ❑ Runaway❑

Part 6. Participant's ethnic and racial identities (optional):

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

Don't fill out this part. This is for official use only:

CHILD AND ADULT CARE FOOD PROGRAM
MEAL BENEFIT INCOME ELIGIBILITY FORM (Family Day Care Home-Provider)
FISCAL YEAR 2023

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

Eligibility: Tier I_____ Tier II_____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____