



Name of Child Care Center: \_\_\_\_\_

CACFP Meal Benefit Income Eligibility Statement\*

**PART I: Child(ren) or Adult enrolled to receive day care**

Name: (Last, First and Middle Initial)	Date of Birth (Optional) MM/DD/YY	SNAP, TANF, or FDIPIR case number, or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. <b>Note: Do not use EBT numbers. Write case number and proceed to Part III.</b>	Children in Head Start, foster care and children who meet the definition of migrant, runaway, or homeless are eligible for free meals. Check (✓) all that apply. (See definitions in FAQs)				
			Head Start	Foster Child	Migrant	Runaway	Homeless
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PART II: Report income for ALL Household Members (Skip this step if participant is categorically eligible as documented in Part I.) Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information**

**A. Child Income** - Sometimes children in the household earn or receive income. Please indicate the TOTAL income received by child household members listed in PART I here. All children income/How often? \$ \_\_\_\_\_ / \_\_\_\_\_

**B. Other Household Members.** List all household members even if they do not receive income. Also, list the adult participant if he/she did not meet eligibility in Part I. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter "0" or leave any field blank you are certifying (promising) there is no income to report.

Name of Other Household Members (First and Last)	1. Earnings from work before deductions / How often	2. Welfare, child support, alimony / How Often	3. Social Security, pensions, retirement / How Often	4. All other income / How Often
(Example) Jane Smith	\$ 200/week	\$ 150/twice a month	\$ 100/month	\$ _____ / _____
1. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
2. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
3. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
4. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
5. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

**C. Total Household Members (Adults and Children) listed in Part I and Part II** \_\_\_\_\_

**D. Social Security Number.** If income is listed or completed in Part II, the adult completing the form must also list the last four digits of his or her Social Security Number or check the "I don't have a Social Security Number" box below. (See Privacy Act Statement on next page). Failure to complete this section, if income is listed, will result in the denial of free or reduced eligibility. Last four Digits of Social Security Number XXX-XX-\_\_\_\_ I do not have a Social Security Number

**PART III: Enrollment Information: Children Only**

My child is normally in attendance at the facility between the hours of \_\_\_\_\_ [am/pm] to \_\_\_\_\_ [am/pm].  (✓) Check here if only before/after school care is provided. Circle the days your child will normally attend the center: Sunday Monday Tuesday Wednesday Thursday Friday Saturday Circle the meals your child will normally receive while in care: Breakfast AM Snack Lunch PM Snack Supper Evening Snack

**PART IV: Signature**

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 purposefully give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted. This signature also acknowledges that the child(ren) or adult listed on the form in Part I are enrolled for care. If not completed fully and signed, the participant will be placed in the Paid category.

Signature: X \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

**PART V: Participant's Ethnic and Racial Identities (optional)**

Check (✓) one ethnic identity:  Hispanic/Latino  Not Hispanic/Latino Check (✓) one or more racial identities:  Asian  White  Black or African American  Indian or Alaska Native  Hawaiian or other Pacific Islander

Official Use Only Section for QCC Staff: Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12

(A) Total income: \_\_\_\_\_ per  Week  Every 2 weeks  Twice a month  Year (B) Household Size: \_\_\_\_\_ (C) Categorical Eligibility:  (Check if applicable) (D) Eligibility:  Free  Reduced  Paid (E) Day Care Homes Only: Check one  Tier I  Tier II (F) Time Period: \_\_\_\_\_

When more than one person is performing CACFP duties, there must be at least two signatures on this form: one signature from the Determining Official (the official who determined initial income classification) and one signature from the Confirming Official (the official who verified the form's accuracy).

Determining Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Confirming Official's Signature \_\_\_\_\_ Date: \_\_\_\_\_ Follow Up Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_