



INSTRUCTIONS FOR COMPLETING THE CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM

Follow these instructions, if your household gets FOOD STAMPS, TANF, FDPIR, SSI or Medicaid:

- Part 1:** For family day care home and child care center, list participant's name and a Food Stamp, TANF or FDPIR case number. For adult day care, list participant's name and a Food Stamp, TANF, FDRIP, SSI or Medicaid case number.
- Part 2:** Skip this part.
- Part 3:** Skip this part.
- Part 4:** Sign the form. A Social Security Number is not necessary.
- Part 5:** Answer this question if you choose to.

If you are applying on behalf of a FOSTER CHILD, use a separate application for each foster child and follow these instructions:

- Part 1:** Enter the child's name.
- Part 2:** Please contact us at **[Phone Number]**.
- Part 3:** Skip this part.
- Part 4:** Sign the form. A Social Security Number is not necessary.
- Part 5:** Answer this question if you choose to.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

- Part 1:** List each participant's name.
- Part 2:** Skip this part.
- Part 3:** Follow these instructions to report total household income from last month.
- Column A–Name:** List the first and last name of **each** person living in your household, related or not (such as grandparents, other relatives, or friends who live with you). You must include yourself and all children living with you. Attach another sheet of paper if you need to.
- Column B–Gross income last month and how often it was received.** Next to each person's name, list each type of income received last month, and how often it was received.
- In Box 1, list the **gross income** each person earned from work. This is not the same as take-home pay. **Gross income is the amount earned before taxes and other deductions.** The amount should be listed on your pay stub, or your boss can tell you. Next to the amount, write how often the person got it (weekly, every other week, twice a month, or monthly).
- In box 2, list the amount each person got last month from welfare, child support, alimony.
- In box 3, list Social Security, pensions, and retirement.
- In box 4, list ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits, regular contributions from people who do not live in your household. Report net income for self-owned business, farm, or rental income. Next to the amount, write how often the person got it. If you are in the Military Housing Privatization Initiative do not include this housing allowance.
- Column C–Check if no income:** If the person does not have any income, check the box.
- Part 4:** An adult household member must sign the form and list his or her Social Security Number, or mark the box if he or she doesn't have one.
- Part 5:** Answer this question if you choose to.

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

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.



**CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
MEAL BENEFIT INCOME ELIGIBILITY FORM**

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| Part 1. Children or adults enrolled to receive day care. (Use a separate application for each foster child) | |
| Names (First, Middle Initial, Last) | Food Stamp, TANF or FDPIR case # for <u>children only</u> . All the above or SSI or Medicaid case # for <u>adults only</u> . Skip to Part 4 if you listed a case #. |
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Part 2. Foster Child: In certain cases, foster children are eligible for free and reduced-price meals regardless of household income. If foster children live with you, please contact **[name]** and **[phone number]**. Skip to Part 4.

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|---|---|------------------------------------|---|---------------------|------------------------------|
| Part 3. Total Household Gross Income—You must tell us how much and how often | | | | | |
| A. Name (List everyone in household, including children) <i>(Example)</i> Jane Smith | B. Gross income and how often it was received <i>Example: \$100/monthly \$100/twice a month \$100/every other week \$100/weekly</i> | | | | C. Check if NO income |
| | 1. Earnings from work before deductions | 2. Welfare, child support, alimony | 3. Social Security, pensions, retirement, | 4. All Other Income | |
| | \$_____ / _____ | \$_____ / _____ | \$_____ / _____ | \$_____ / _____ | <input type="checkbox"/> |
| | \$_____ / _____ | \$_____ / _____ | \$_____ / _____ | \$_____ / _____ | <input type="checkbox"/> |
| | \$_____ / _____ | \$_____ / _____ | \$_____ / _____ | \$_____ / _____ | <input type="checkbox"/> |
| | \$_____ / _____ | \$_____ / _____ | \$_____ / _____ | \$_____ / _____ | <input type="checkbox"/> |
| | \$_____ / _____ | \$_____ / _____ | \$_____ / _____ | \$_____ / _____ | <input type="checkbox"/> |
| | \$_____ / _____ | \$_____ / _____ | \$_____ / _____ | \$_____ / _____ | <input type="checkbox"/> |
| | \$_____ / _____ | \$_____ / _____ | \$_____ / _____ | \$_____ / _____ | <input type="checkbox"/> |

Part 4. Signature and Social Security Number (Adult must sign)
An adult household member must sign this form. If Part 3 is completed, the adult signing the form must also list his or her Social Security Number or mark the "I do not have a Social Security Number" box. (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 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 purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: X _____ Print name: _____ Date: _____
Address: _____ Phone Number: _____
Social Security Number: _____ - _____ - _____ I do not have a Social Security Number

| | |
|--|---|
| Part 5. Participant's ethnic and racial identities (optional) | |
| Mark one ethnic identity: | Mark one or more racial identities: |
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native |
| <input type="checkbox"/> Not Hispanic or Latino | <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| | <input type="checkbox"/> Black or African American |

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

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: _____
Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free ___ Reduced ___ Denied ___
Reason: _____
Temporary: Free ___ Reduced ___ Time Period: _____ (expires after ___ days)
Determining Official's Signature: _____ Date: _____
Confirming Official's Signature: _____ Date: _____



CHILD AND ADULT CARE FOOD PROGRAM
SHARING INFORMATION WITH MEDICAID/SCHIP

Dear Parent/Guardian:

If your children qualify for free or reduced price meals, they may also be able to get free or low cost health insurance through Medicaid or the State Children's Health Insurance Program (SCHIP). Children with health insurance are more likely to get regular health care and are less likely to become sick.

Because health insurance is so important to children's well-being, **the law allows us to tell Medicaid and SCHIP that your children are eligible for free or reduced price meals, unless you tell us not to.** Medicaid and SCHIP only use the information to identify children who may be eligible for their programs. Program officials may contact you to offer to enroll your children in this health insurance program. Filling out the CACFP Meal Benefit Income Eligibility Forms does not automatically enroll your children in health insurance.

If you do not want us to share your information with Medicaid or SCHIP, fill out the form below and send it with your Income Eligibility Form to **[address] by [date]**. (Sending in this form will not change whether your children get free or reduced price meals.)

No! I DO NOT want information from my CACFP Meal Benefit Income Eligibility Form shared with Medicaid or the State Children's Health Insurance Program.

If you checked no, fill out the form below.

Child's Name: _____

Child's Name: _____

Child's Name: _____

Child's Name: _____

Signature of Parent/Guardian: _____

Today's Date: _____

Print Your Name: _____

Address: _____

For more information, you may call **[name]** at **[phone]**