

## CACFP APPLICATION FOR FREE AND REDUCED PRICE MEALS (CHILD CARE)

<b>SPONSOR NAME:</b> EARLY CHILDHOOD ALLIANCE	<b>PHONE NUMBER:</b> 260-745-2501
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<b>CENTER:</b>	<b>FDC PROVIDER:</b>
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<b><u>PART 1. ALL HOUSEHOLD MEMBERS</u></b>		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
NAMES OF ALL HOUSEHOLD (FIRST, MIDDLE INITIAL, LAST)	BIRTH DATES OF CHILDREN		
		<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 2. BENEFITS:** IF ANY MEMBER OF YOUR HOUSEHOLD RECEIVED [FOOD STAMPS] OR [STATE TANF CASH ASSISTANCE], PROVIDE THE NAME AND CASE NUMBER FOR THE PERSON WHO RECEIVES BENEFITS. **IF NO ONE RECEIVES THESE BENEFITS, SKIP TO PART 3.**

NAME: \_\_\_\_\_ CASE NUMBER: \_\_\_\_\_

**PART 3.** IF ANY CHILD YOU ARE APPLYING FOR IS HOMELESS, MIGRANT, OR A RUNAWAY CHECK THE APPROPRIATE BOX AND CALL [INSERT CENTER CONTACT AND PHONE NUMBER]      HOMELESS       MIGRANT       RUNAWAY

**PART 4. 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			
	1. EARNINGS FROM WORK BEFORE DEDUCTIONS	2. WELFARE, CHILD SUPPORT, ALIMONY	3. PENSIONS, RETIREMENT, SOCIAL SECURITY, SSI, VA BENEFITS	4. ALL OTHER INCOME
(EXAMPLE) JANE SMITH	\$200/WEEKLY _____	\$150/TWICE A MONTH _____	\$100/MONTHLY _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

**PART 5. SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (ADULT MUST SIGN)**

AN ADULT HOUSEHOLD MEMBER MUST SIGN THIS FORM. IF PART 4 IS COMPLETED, THE ADULT SIGNING THE FORM MUST ALSO LIST THE LAST FOUR DIGITS OF 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: \_\_\_\_\_ PRINT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER: XXX - XX - \_\_\_\_\_  I DO NOT HAVE A SOCIAL SECURITY NUMBER

\_\_\_\_\_ Initial here if you consent to allow [Provider's Name] to collect your form and provide it to the Sponsor. [Provider's Name] will not review your form.

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A CHILD ENROLLED IN THE DAY CARE FACILITY MAY QUALIFY FOR FREE OR REDUCED PRICE MEALS IF THE HOUSEHOLD INCOME FALLS AT OR BELOW THE LIMITS ON THIS CHART:

JULY 1, 2014 TO JUNE 30, 2015			
HOUSEHOLD SIZE	MONTHLY INCOME	HOUSEHOLD SIZE	MONTHLY INCOME
1	1,800	5	4,303
2	2,426	6	4,929
3	3,051	7	5,555
4	3,677	8	6,181
FOR EACH ADDITIONAL FAMILY MEMBER, ADD \$626			

PART 6. PARTICIPANT'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)	
MARK ONE ETHNIC IDENTITY: <input type="checkbox"/> HISPANIC OR LATINO  <input type="checkbox"/> NOT HISPANIC OR LATINO	MARK ONE OR MORE RACIAL IDENTITIES: <input type="checkbox"/> ASIAN <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> WHITE <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER <input type="checkbox"/> BLACK OR AFRICAN AMERICAN

**PART 7: OTHER BENEFITS:** THE LAW ALLOWS US TO TELL MEDICAID AND HOOSIER HEALTHWISE THAT YOUR CHILDREN ARE ELIGIBLE FOR FREE OR REDUCED-PRICE MEALS. WE MAY SHARE YOUR APPLICATION INFORMATION WITH MEDICAID OR HOOSIER HEALTHWISE UNLESS YOU DO NOT WANT US TO. IF YOU DO NOT WANT US TO SHARE THIS INFORMATION, SIGN HERE:

FOR INFORMATION ABOUT HOOSIER HEALTHWISE HEALTH INSURANCE  
CALL 1-800-889-9949

SIGNATURE OF PARENT OR LEGAL GUARDIAN \_\_\_\_\_

**PRIVACY ACT STATEMENT:** 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.

*The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)*

*If you wish to file a Civil Rights program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](http://www.ascr.usda.gov/complaint_filing_cust.html), found online at [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at [program.intake@usda.gov](mailto:program.intake@usda.gov).*

*Individuals who are deaf, hard of hearing 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.*

CHILD CARE REPRESENTATIVE USE ONLY	
ANNUAL INCOME CONVERSION: <u>WEEKLY X 52</u> – <u>EVERY 2 WEEKS X 26</u> – <u>TWICE A MONTH X 24</u> – <u>MONTHLY X 12</u>	
<b>SECTION A</b> MARK ONE OF THE BOXES BELOW TO SHOW HOW YOU ARE GOING TO DETERMINE ELIGIBILITY.  <input type="checkbox"/> <b>FOOD STAMP OR TANF HOUSEHOLD</b> —THE FOOD STAMP OR TANF NUMBER MEETS THE CRITERIA FOR AN ACCEPTABLE CASE NUMBER. COMPLETE SECTION B & C <b>OR</b>  <input type="checkbox"/> <b>FOSTER CHILD</b> —COMPARE THE FOSTER CHILD'S PERSONAL INCOME TO THE GUIDELINES. COMPLETE SECTION B & C <b>OR</b>  <input type="checkbox"/> <b>HOUSEHOLD INCOME</b> —COMPLETE THE INFORMATION BELOW AND COMPLETE SECTION B & C  TOTAL HOUSEHOLD SIZE: _____  TOTAL HOUSEHOLD INCOME \$ _____ / _____ EXAMPLE: \$100/WEEK  COMPARE TOTAL HOUSEHOLD INCOME TO CURRENT USDA INCOME ELIGIBILITY GUIDELINES. WHEN THE HOUSEHOLD INCOMES ARE LISTED FOR DIFFERENT PAY PERIODS, YOU MUST CONVERT ALL INCOME TO MONTHLY OR ANNUAL INCOME. USE THE CONVERSION LISTED ABOVE.	<b>SECTION B</b> BASED ON THE INFORMATION PROVIDED, THIS APPLICATION WILL BE: <input type="checkbox"/> APPROVED FREE <input type="checkbox"/> APPROVED TIER I <input type="checkbox"/> APPROVED REDUCED <input type="checkbox"/> APPROVED TIER II <input type="checkbox"/> PAID  USE THIS SPACE FOR INCOME CALCULATION.          <b>SECTION C</b>  _____ SIGNATURE OF SPONSOR REPRESENTATIVE  _____ DATE OF APPROVAL  <p style="text-align: center;"><b>THIS FORM EXPIRES ONE YEAR FROM THE DATE IT WAS APPROVED</b></p>

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