

CHILD AND ADULT CARE FOOD PROGRAM: CHILD CARE COMPONENT
INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED PRICE MEALS FY 2014 – 2015

FY2014 – FY2015 (7/1/14 – 6/30/15) INSTRUCTIONS: To apply for free and reduced-price meals, read the Household Letter and instructions on backside of this form. Complete application and return to the center. In accordance with the NSLA, information on this application may be disclosed to other Child Nutrition Programs or applicable enforcement agencies. Parents/guardians are not required to consent to this disclosure. *Part 1* is to be completed by all households. *Part 2* is to be used only for a child living in a household receiving Food Assistance or Ohio Works First (OWF) benefits. *Part 3* is only for children NOT receiving Food Assistance or OWF benefits. *Part 4* an adult household member must sign and date form; the last 4 digits of social security number must be listed if Part 3 is completed. *Part 5* is optional. * Asterisks indicate info that must be completed. Form must be completed annually and is valid for only 12 mo.

CENTER NAME			CHECK IF A FOSTER CHILD (The legal responsibility of a welfare agency or court)	PART 2 – LIST EACH CHILD'S FOOD ASSISTANCE OR OWF CASE NUMBER, IF ANY. A VALID CASE NUMBER CONTAINS 10 OR 12 DIGITS. DO NOT USE SWIPE CARD NUMBER. 600... numbers not valid.	
PART 1 – PRINT INFORMATION FOR ALL CHILDREN ENROLLED AT CENTER					
* NAME OF ENROLLED CHILD(REN)	AGE	BIRTH DATE		Circle type of benefit: FOOD ASSISTANCE or OWF	
1.			<input type="checkbox"/>	CASE NO.	_____
2.			<input type="checkbox"/>	CASE NO.	_____
3.			<input type="checkbox"/>	CASE NO.	_____
4.			<input type="checkbox"/>	CASE NO.	_____

PART 3 – TOTAL HOUSEHOLD SIZE, TOTAL HOUSEHOLD GROSS INCOME AND HOW OFTEN IT WAS RECEIVED: List names of all household members. List all gross income: list how much and how often. If Part 2 is completed, skip to Part 4.

a. LIST NAMES OF ALL HOUSEHOLD MEMBERS INCLUDING CHILDREN LISTED ABOVE IN PART 1	b. CHECK IF NO/ZERO INCOME	c. GROSS INCOME during the last month (amount earned before taxes & other deductions) and HOW OFTEN IT WAS RECEIVED: Weekly, Every 2 Weeks, Twice Per Month, Monthly, Annually			
		1. Earnings from work before deductions	2. Welfare payments, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA	4. All Other Income
EXAMPLE: JANE SMITH		\$ 200 / weekly	\$ 150 / twice month	\$ 100 / monthly	\$ _____ / _____
1.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
2.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
3.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
4.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
5.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
6.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

PART 4 – SIGNATURE AND LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: Adult household member must sign/date form. If Part 3 is completed, the adult signing the form must also list last 4 digits of his/her Social Security Number or check the "I do not have a Social Security Number" box.

I certify that all information on this form is true and correct and that all income is reported. I understand that the center will get Federal Funds based on the information. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, I may be prosecuted.

* _____ SIGNATURE OF ADULT HOUSEHOLD MEMBER	* _____ DATE	* If Part 3 is completed, insert last 4 digits of Social Security Number (check if applicable)	____	____	____	____
Print Name:		Daytime Phone Number:	Work Phone Number:			
Street / Apt:		City / State / Zip:	County:			

PART 5: RACIAL/ETHNIC IDENTITY (Optional): Please check appropriate boxes to identify the race or ethnicity of enrolled child(ren).

<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Other

Please mark one ethnic identity: Hispanic or Latino Not Hispanic or Latino

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.

State Distribution: 6/20/2014

THIS SECTION TO BE COMPLETED BY CENTER. Note: All information above this section is to be filled in by the parent or guardian.

Complete information below only if qualifying child(ren) by household income from Part 3. Per the total household size, compare total household income to the USDA Income Eligibility Guidelines to determine correct categorization. When income is listed in different frequencies of pay in Part 3, you must convert all income to annual income before determination. Use the following Annual Income Conversion: Weekly x 52, Every 2 Weeks (bi-weekly) x 26, Twice per Month (semi-monthly) x 24, Monthly x 12		Application Categorized as: <input type="checkbox"/> FREE , based on <input type="checkbox"/> Food Assistance/OWF Case No. <input type="checkbox"/> Household Size & Income <input type="checkbox"/> Foster Child
Total Household Size: _____	Total Household Income: \$ _____ Per: <input type="checkbox"/> Week <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice Per Month <input type="checkbox"/> Month <input type="checkbox"/> Year	<input type="checkbox"/> REDUCED , based on Household Size & Income
		<input type="checkbox"/> PAID , based on <input type="checkbox"/> Income Too High <input type="checkbox"/> Incomplete <input type="checkbox"/> Invalid case number or information

Signature of Sponsor / Center Representative _____	Date Sponsor Categorized _____	Effective Date _____ (From the first of month of date categorized by sponsor/center)	Expiration Date _____ (Valid until last day of month of which form was dated and categorized by sponsor/center one year earlier)
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Note: If using parent signature date to determine effective/expiration date of all forms, then option must be selected on FY 15 CRRS management plan.

