Child Adult Care Food Program

Income Eligibility Statement

PART I: Child or Adult enrolled to receive day care-

Name: (Last, First and Middle Initial)	Food Stamp, TANF, or FDPIR case number, Assistant Unit (AU), or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. Note: Do not use EBT numbers.	Head Start Participant
		☐
		☐
		☐
		☐
		☐
		☐
		☐

PART II: FOSTER CHILD: If this is a foster child, check here ☐. In certain cases, foster children are eligible for free and reduced-priced meals regardless of household income. If foster children live with you, please contact [_____] at [___-___-____]. Skip to Part IV.

PART III A: A. Name (List everyone in household, including children)	B. Gross income and how often it is received. Example: $100/monthly, $100/twice a month, $100/every other week, $100/weekly				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	
1. _____	$____/____	$____/____	$____/____	$____/____	☐
2. _____	$____/____	$____/____	$____/____	$____/____	☐
3. _____	$____/____	$____/____	$____/____	$____/____	☐
4. _____	$____/____	$____/____	$____/____	$____/____	☐
5. _____	$____/____	$____/____	$____/____	$____/____	☐
6. _____	$____/____	$____/____	$____/____	$____/____	☐
7. _____	$____/____	$____/____	$____/____	$____/____	☐

PART III-B: ENROLLMENT INFORMATION: Children Only

My child is normally in attendance at the facility between the hours of _____ [am/pm] to _____ [am/pm] on the following days:

☐ Check here if only before/after school care is provided.

(Circle all that apply). Sunday Monday Tuesday Wednesday Thursday Friday Saturday

My child will normally receive the following meals while in care:

(Circle all that apply): Breakfast AM Snack Lunch PM Snack Supper Evening Snack

PART IV: Signature and Social Security Number (Adult must sign).

An adult household member must sign this form. If Part III is completed the adult signing the form must also list his or her Social Security number or mark the "I don't have a Social Security Number" box. (See Privacy Act Statement on next 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 purposefully give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Signature: X_____ **Print Name** _____ **Date**_____

Address: _____ **City** _____ **State: GA Zip**_____ **Phone** _____

Social Security Number _____ ☐ I do not have a Social Security Number

PART V: Participant's ethnic and racial identities (optional)

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

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 _____ Paid _____ Tier I _____ Tier II _____

Temporary: Free _____ Reduced _____ Time Period: _____ (expires after _____days)

Determining Official's Signature: _____ Date_____

Confirming Official's Signature: _____ Date_____

Follow Up Official's Signature: _____ Date_____