FY 2012 CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

FAMILY-SIZE AND INCOME APPLICATION

PART 1. ALL HOUSEHOLD MEMBERS

a. Name(s) of Enrolled Child(ren)

b. Names of *ALL* Household Members (First, Middle Initial, Last)	Age of Enrolled Child(ren)	Birth Date of Enrolled Child(ren)	Check If a Foster Child (The Legal Responsibility of a Welfare Agency or Court)* *If all children indicated below are foster children, skip to Part 5 to sign this form.	Check if *NO* Income
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

PART 2. BENEFITS

If any member of your household receives *SNAP, TANF,* or *FDPIR* benefits, provide the name and case number for the *ONE* 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 *(YOUR SCHOOL HOMELESS LIAISON OR MIGRANT COORDINATOR AT 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			
	Earnings From Work Before Deductions	Welfare, Child Support, Alimony	Pensions, Retirement, Social Security, SSI, VA Benefits	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 also must 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 the next page.)

I certify that all information on this form is true and that all income is reported. I understand that the center will get federal funds based on the information that 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: * - **- ___ ___ ___ ___** ☐ I do not have a social security number.

Part 6: Participant's Ethnic and Racial Identities (Optional)

Mark one ethnic identity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Mark one or more racial identities:
☐ Asian
☐ White
☐ American Indian or Alaska Native
☐ Native Hawaiian or other Pacific Islander
☐ Black or African American

PART 7: *OTHER BENEFITS*: You do not have to complete this part to participate in the CACFP.

Health Insurance

☐ Yes, I want health insurance for my children. Insitution officials may give information from my FSIA to SoonerCare Health Benefit officials so that they can send me information about free or low-cost health insurance for my children.

☐ No, I *DO NOT* want information from my FSIA shared with SoonerCare Health Benefits officials.

I certify that I am the parent/guardian of the children for whom application is being made.

I understand that I will be releasing information that will show that I qualify for free or reduced-price meals for my children. I give up my rights to confidentiality for this purpose only.

Signature of Parent/Guardian: ____________________ Date: ____________

DO NOT 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 45 days)

Determining Official's Signature: ____________________ Date: ____________

The participant in the day care facility may qualify for free or reduced-price meals if your household income falls within the limits of this chart.

185% of Poverty Level

Household Size	Yearly
1	20,147
2	27,214
3	34,281
4	41,348
5	48,415
6	55,482
7	62,549
8	69,616
Each additional person:	7,067

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 last four digits of 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), or Food Distribution Program on Indian Reservations (FDPIR) case number 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 Programs.

Nondiscrimination Statement: This explains what to do if you believe you have been treated unfairly. "In accordance with federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C., 20250-9410 or call toll free 866-632-9992 (Voice). Individuals who are hearing-impaired 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 AND ADULT CARE FOOD PROGRAM (CACFP)
ENROLLMENT FORM

CHILD'S INFORMATION

1. Child's Name: ______________________________ Date of Birth: ____________

2. Normal Days in Attendance:

SUN	MON	TUE	WED	THU	FRI	SAT

3. Head Start Facilities Only: Indicate session and sign and date form.

   ☐ A.M. ☐ P.M. ☐ All Day

4. **Special Dietary Needs*** ☐ **Yes** ☐ **No**

5. Normal Hours of Attendance: ____________ a.m./p.m. to: ____________ a.m./p.m.

6. Normal Meals Eaten:

   ☐ Breakfast ☐ Lunch ☐ Supper

   ☐ A.M. Snack ☐ P.M. Snack ☐ Late P.M. Snack

7. Signature of Parent/Guardian: ______________________________ Date: ____________

*Attach signed medical statement.

PARENT'S INFORMATION

Name of Parent/Guardian: ______________________________

Address: ______________________________ City: ____________________ Zip: ________

Home Telephone Number: ______________________________

RENEWAL UPDATES

If there are no changes to the above information, sign and date. If there are changes, a new enrollment form must be completed, signed, and dated.

Parent/Guardian Signature	**Date**