

## Family Meal Application for Child Care Centers and Family Day Care Homes 2017-2018

<b>Part 1. All Household Members</b>				
<b>Name of Enrolled Child(ren):</b>				
<b>NAMES OF ALL HOUSEHOLD MEMBERS</b> (First, Middle Initial, Last)	<b>CHECK IF A FOSTER CHILD</b> (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM			<b>CHECK IF NO INCOME</b>
	<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"/>
<b>Part 2. Benefits:</b> If any member of your household received [MS SNAP], [FDPIR], or [MSTANF cash assistance], provide the name and case number for the person who receives benefits. <b>If no one receives these benefits, skip to part 3.</b>				
NAME: _____ CASE NUMBER: _____				
<b>Part 3.</b> If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call:				
_____ [Your School, Homeless Liaison, Migrant Coordinator at Phone #]				
<input type="checkbox"/> Homeless <input type="checkbox"/> Migrant <input type="checkbox"/> Runaway				
<b>Part 4. Total Household Gross Income—You must tell us how much and how often</b>				
<b>A. Name</b> (List <b>only</b> household members with income)	<b>B. Gross income and how often it was received</b>			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
<i>(Example)</i> Jane Smith	\$200 / weekly	\$150 / twice a month	\$100 / monthly	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
<b>Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)</b>				
An adult household member must sign this form. <b>If Part 3 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.</b> (See Statement on the back of this page.)				
<i>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.</i>				
Sign here: _____		Print name: _____		
Date: _____				
Address: _____		Phone Number: _____		
City: _____		State: _____		Zip Code: _____
Last four digits of Social Security Number:    ___ ___ ___ ___ <input type="checkbox"/> I do not have a Social Security Number				

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<b>Part 6. Participant's ethnic and racial identities (optional)</b>	
Mark one ethnic identity:	Mark one or more racial identities:
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Asian
<input type="checkbox"/> Not Hispanic or Latino	<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
<b>Don't fill out this part. This is for official use only.</b>	
Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12	
Total Income: _____ Per: <input type="checkbox"/> Week, <input type="checkbox"/> Every 2 Weeks, <input type="checkbox"/> Twice A Month, <input type="checkbox"/> Month, <input type="checkbox"/> Year	Household size: _____
Categorical Eligibility: _____ Date Withdrawn: _____ Eligibility: Free ___ Reduced ___ Denied ___	Tier I _____ Tier II _____
Reason: _____	
Temporary: Free ___ Reduced ___ Time Period: _____ (expires after _____ days)	
Determining Official's Signature: _____	Date: _____
Confirming Official's Signature: _____	Date: _____
Follow-up 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 on this chart.**

Household size	Yearly
1	\$ 22,311
2	\$ 30,044
3	\$ 37,777
4	\$ 45,510
5	\$ 53,243
6	\$ 60,976
7	\$ 68,709
8	\$ 76,442
Each additional person:	\$ 7,733

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.

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Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the responsible Agency or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at [How to File a Program Discrimination Complaint](#) and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

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