INSTRUCTIONS FOR CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (CHILD CARE)

Follow these instructions, if your household gets SNAP, TANF or FDPIR:

- Part 1: List all enrolled children and household members.
- **Part 2:** List the eligibility number for any household members (including adults) receiving SNAP or TANF or FDPIR benefits. The SNAP or TANF number must be the 8 or 9 digit EDG# assigned by HHSC.
- Part 3: Skip this part.
- Part 4: Skip this part.
- **Part 5:** Sign the form. The last four digits of a Social Security Number are **not** necessary.
- Part 6: Answer this question if you choose.
- Part 7: Answer this question if you choose.

If you are applying on behalf of a FOSTER CHILD, follow these instructions:

If **all** children you are applying for are foster children, or if you are only applying for benefits for the foster child:

- **Part 1:** List all foster children. Check the box indicating that the child is a foster child.
- **Part 2:** Skip this part.
- Part 3: Skip this part.
- Part 4: Skip this part.
- Part 5: Sign the form. A Social Security Number is **not** necessary.
- Part 6: Answer this question if you choose.
- Part 7: Answer this question if you choose.

If some of the children in the household are foster children.

- **Part 1:** List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster child.
- Part 2: If the household does not have an eligibility number, skip this part.
- Part 3: Applies only to parents/guardians of children in Tier II Day Care Homes. Sponsors must provide the List of Eligible Federal/State Funded Programs (H1660), with this form to households with children enrolled in Tier II Day Care Homes. Parents/Guardians can enter the program name and number as applicable.
- Part 4: Follow these instructions to report total household income from this month or last month.
 - **Column A Name:** List only the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.
 - **Column B Gross Income and How Often it was Received:** For each household member, list each type of income received for the month. You must tell us how often the money is received weekly, every other week, twice a month, or monthly.
 - Box 1: List the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.
 - Box 2: List the amount each person got from the month from welfare, child support, alimony.
 - **Box 3:** List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. *For ONLY the self-employed, report income after expenses in Box 1*. Box 4 is for your business, farm or rental property. Do not include income from SNAP, TANF, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box."

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Follow these instructions to report total household income from this month or last month.

Column A – Name: List only the first and last name of each person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.

Box 2: List the amount each person got from the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. *For ONLY the self-employed, report income after expenses in Box 1*. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

Privacy Act Statement: This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.



CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members					
Name of Enrolled Child(ren):			_		_
Names of all household members (First, Middle Initial, Last)			LEGAL RE WELFARE * IF ALL C ARE FOST	A FOSTER CHILD (THE SPONSIBILITY OF A AGENCY OR COURT) HILDREN LISTED BELOW ER CHILDREN, SKIP TO SIGN THIS FORM.	CHECK IF NO INCOME
(,					
					10
					<u> </u>
					
Part 2. Benefits: If any member of y person who receives benefits. If no NAME:	one receives these be	enefits, skip to	part 3.	_	
Part 3. (Applies only to parents/gua benefits listed on the enclosed <i>List of</i> number: NAME: Check here if no eligibility number □	f Eligible Federal/State	Funded Prograr ELIG	ns (H1660), p BIBILITY NUI	provide the name of the prog MBER:	ram and eligibility
Part 4. Total Household Gross Inco					
	B. Gross income and			a in land 4	
A. Name (List only household members with income)	Note: Self-employed 1. Earnings from work before deductions			3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example)	\$200/weekly	\$150/twice a m	onth	\$100/monthly	\$200/bi-monthly
Jane Smith	\$/	\$/_		\$/_	\$/
	\$	\$/_		\$/_	\$
	\$/	\$/		\$/	\$/
	\$/	\$/		\$/	\$/
	\$/	\$/		\$/	\$/
Part 5. Signature and Last Four Di An adult household member must si of his or her Social Security Numb next page.) I certify that all information on this for	gn this form. If Part 4 is per or mark the "I do r arm is true and that all in	s completed, the not have a Social accome is reported	e adult sign al Security N	ing the form must also list lumber" box. (See Privacy and that the center or day care	Act Statement on the
Federal funds based on the information purposely give false information, the	participant receiving m	eals may lose ti	he meal bene	fits, and I may be prosecuted	d.
Sign here:		Print na	me:		
Date:					
Address:		Phone I	Number:		
City:		State: _		Zip Code:	
Last four digits of Social Security Nu	ımber: <u>* * * * - *</u> - <u>*</u>		☐ I do notha	ave a Social Security Number	-



CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 6. Participant's ethnic and					
Mark one ethnic identity: Hispanic or Latino	Mark one or more racial identities: ☐ Asian ☐ American Indian or Alaska Native				
☐ Not Hispanic or Latino	☐ White ☐ Native Hawaiian or Other Pacific				
	☐ Black or African American				
	th Other Programs: OPTIONAL				
The above information may be disclosed for the purpose of enrolling children in the Children's Health Insurance Program (CHIP).					
Parents/guardians are not required to consent to such disclosure and electing not to allow disclosure will not adversely affect a child's					
eligibility.	eligibility.				
☐ I do elect to allow my household information to be disclosed.					
☐ I <u>do not</u> elect to allow my household information to be disclosed.					
Don't 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: Pe	er: 🗆 Week, 🗅 Every 2 Weeks, 🗅 Twice A Month, 🗅 Month, 🗅 Year	Household size:			
Categorical Eligibility: Date	Withdrawn: Eligibility: Free Reduced Denied	Tier I Tier II			
Reason:					
Determining Official's Signature	•	Date:			
Confirming Official's Signature:		Date:			
Follow-up Official's Signature: _		Date:			
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) eligibility 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.					
Non-discrimination Statement:					
In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.					
Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.					
	y that administers the program or USDA's TARGET Center at (202) 720				
USDA through the Federal Relay To file a program discrimination Form which can be obtained onl 0002-508-11-28-17Fax2Mail.pdf, must contain the complainant's r	y that administers the program or USDA's TARGET Center at (202) 720 y Service at (800) 877-8339. complaint, a Complainant should complete a Form AD-3027, USDA Prine at: https://www.usda.gov/sites/default/files/documents/USDA-OAS0 , from any USDA office, by calling (866) 632-9992, or by writing a letter name, address, telephone number, and a written description of the alleged cretary for Civil Rights (ASCR) about the nature and date of an alleged	ogram Discrimination Complaint CR%20P-Complaint-Form-0508- r addressed to USDA. The letter ged discriminatory action in sufficient			
USDA through the Federal Relay To file a program discrimination Form which can be obtained onl 0002-508-11-28-17Fax2Mail.pdf, must contain the complainant's r detail to inform the Assistant Sec	y that administers the program or USDA's TARGET Center at (202) 720 y Service at (800) 877-8339. complaint, a Complainant should complete a Form AD-3027, USDA Prine at: https://www.usda.gov/sites/default/files/documents/USDA-OAS0, from any USDA office, by calling (866) 632-9992, or by writing a letter name, address, telephone number, and a written description of the allest cretary for Civil Rights (ASCR) about the nature and date of an alleged submitted to USDA by: riculture (2) fax: (833) 256-1665 or (202) 690-7442; or (3) tary for Civil Rights , SW	ogram Discrimination Complaint CR%20P-Complaint-Form-0508- r addressed to USDA. The letter ged discriminatory action in sufficient civil rights violation. The completed			