

Child and Adult Care Food Program Income Eligibility Form

PART 1

Participant's Name: _____ DOB: _____
Last First Middle Initial

White Black Hispanic/Latino Am. Indian/Alaskan Native Hawaiian/Alaskan Asian/Pacific Islander
(Circle one – needed for statistical reporting)

Participant's Name: _____ DOB: _____
Last First Middle Initial

White Black Hispanic/Latino Am. Indian/Alaskan Native Hawaiian/Alaskan Asian/Pacific Islander
(Circle one – needed for statistical reporting)

Start Date: _____ Arrival Time: _____ AM/PM Departure Time: _____ AM/PM Shift Work: Yes/No

Normal days of week Participant(s) is/are in care (circle all that apply): Mon Tues Wed Thurs Fri Sat Sun

Meals eaten at Providers/Center: (Circle all that apply. CACFP provides reimbursement for up to 2 approved meals and one snack per day/participant):

Breakfast AM Snack Lunch PM Snack Supper Evening Snack

PART 2A – HOUSEHOLDS NOW GETTING FOOD STAMPS OR ABC (FORMERLY AFDC): Complete this Part and Part 3 – DO NOT complete Part 2B and C.

Food Stamps Case Number: _____ ABC Case Number: _____

PART 2B – Foster Child (A Foster Child is a ward of the State and a copy of the custody order is required for documentation): Complete this Part and Part 3. DO NOT complete Part 2A or C. If this is a foster child, check here [] and write the child's income and how often it is received here:

\$ _____ / _____

PART 2C – HOUSEHOLD INCOME – If you do not need to complete Part 2A or Part 2B, complete this Part and Part 3.

NAMES CURRENT INCOME (Please indicate by Week/Bi-Wk/2x's Mo/Month/Year)

List Names of All Household Members (Attach Any Additional Members)	Earnings from Work (Before Deductions) Job 1	Welfare, Child Support, Alimony	Payments from Pensions, Retirement, Social Security	Earnings from Job 2 or any Other Income
1	\$ _____	\$ _____	\$ _____	\$ _____
2	\$ _____	\$ _____	\$ _____	\$ _____
3	\$ _____	\$ _____	\$ _____	\$ _____
4	\$ _____	\$ _____	\$ _____	\$ _____
5	\$ _____	\$ _____	\$ _____	\$ _____

PART 3 – SIGNATURE: An adult household member must sign the form before it can be approved.

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that the Food Stamps Number or ABC Number is correct and that all income is reported. I understand that this information is being given for the receipt of Federal funds; that institution officials may verify this information on the statement and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

Printed Name of Adult _____ Signature of Adult _____ Date _____

Home Address: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Social Security Number: _____

(Your Social Security Number is **NOT** needed if you listed a Food Stamps or ABC Number, or the participant is a foster child [Part 2A or Part 2B of this form], or Headstart eligible. For more information, please see instructions for PART 3 on the back of this form.)

Sponsor Use Only: Food Stamps/ABC household/Head-Start categorically eligible for program benefits:
 (If Yes, circle one) [] YES [] NO

Total Family Income: _____ Family Size: _____ (Include all Participants)
Monthly Income Conversion: Weekly x 4.33; Every Two Weeks x 2.15; Twice a Month x 2

Eligible For: FREE [] REDUCED [] PAID [] (NOT Eligible for Free or Reduced or refused income declaration)

Determining Official Signature: _____ Date: _____

