



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)	CHECK IF A FOSTER CHILD (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.			CHECK IF NO INCOME
_____	<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"/>
Part 2. Benefits: If any member of your household receives SNAP, TANF, or FDPIR, provide the name and case number for the person who receives benefits. If no one receives these benefits, skip to part 3. NAME: _____ CASE NUMBER: _____				
Part 3. (Applies only to parents/guardians with children enrolled in a day care home) If any member of your household receives benefits listed on the enclosed <i>List of Eligible Federal/State Funded Programs (H1660)</i> , provide the name of the program and case number: NAME: _____ CASE NUMBER: _____ Check here if no case number <input type="checkbox"/>				
Part 4. Total Household Gross Income—You must tell us how much and how often				
A. Name (List only household members with income) (Example) Jane Smith	B. Gross income and how often it was received Note: Self-employed report income after expenses in box 1			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
	\$200/weekly	\$150/twice a month	\$100/monthly	\$200/bi-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 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. (See Privacy Act Statement on the next 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				