



CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Institution or Facility Name:

Part 1. Name of Child(ren) Enrolled:

Table with 2 columns: Name of Child(ren) Enrolled, checkboxes for Foster Child status.

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.

Full names of all household members

Table for listing household members.

Part 2. Benefits: If any member of your household received [SNAP], [FDPIR] or [TANF cash assistance], 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. If any child you are applying for is homeless, a migrant, or a runaway, call the State agency for instructions.

Part 4. Total Household Gross Income—You must tell us how much and how often (whole dollar amounts, please)

Table for Part 4: Total Household Gross Income. Includes sub-sections A (Name) and B (Gross income and how often it was received).

This section required for all forms listing income in Part 4:

Last four digits of Social Security Number: X X X - X X - \_\_\_\_\_  I do not have a Social Security Number

Part 5. Signature (Adult must sign)

An adult household member must sign this form.

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.

Sign here: \_\_\_\_\_ Print name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

