

Child and Adult Care Food Program (CACFP)

Income Eligibility Application for CACFP Family Day Care Home Providers

For instructions on completing this form, refer to [Instructions for Income Eligibility Application for CACFP Family Day Care Home Providers](#).

Part 1 — Provider information

Provider's name: _____

Part 2A — Providers categorically eligible as Tier I for CACFP benefits

Providers receiving Supplemental Nutrition Assistance Program (SNAP) (formerly known as Food Stamps) or Temporary Family Assistance (TFA) benefits. *Complete this part and part 3. Do **not** complete part 2B.*

SNAP case number: _____ TFA case number: _____

Part 2B — All other households

If you did not complete part 2A, complete this part and part 3.

Names of all household members <i>List everyone in the household, including the provider listed in part 1 above</i>	Gross income and how often it was received: Indicate if income was received monthly, two times a month, every two weeks or weekly by placing the amount of income in the appropriate frequency box. <i>You must place the income in the appropriate frequency box.</i>											
	Earnings from work (before deductions) – job 1				Public assistance/ alimony/ child support				Pensions/retirement/social security/all other income			
Names	Weekly	Biweekly Every 2 weeks	2 X Month	Monthly	Weekly	Biweekly Every 2 weeks	2 X Month	Monthl y	Weekly	Biweekly Every 2 weeks	2 X Month	Monthly
(Example) Jane Smith	\$200					\$134						
1.												
2.												
3.												
4.												
5.												
6.												
7.												
8.												

Part 3 — Contact information, signature, and social security number

*The provider must **sign and date** this form before it can be approved.*

I certify (promise) that all information on this form is true and that all income is reported. I understand that the day care home will receive federal funds based on the information I provide. I understand that CACFP officials may verify (check) the information. I understand if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable state and federal laws.

Printed name of provider: _____ Signature: _____

Date: _____ Last four digits of Social Security Number (SSN): XXX-XX- _____ I do not have a SSN

Home telephone: _____ Work telephone: _____

Home address: _____ City: _____ State: _____ Zip Code: _____

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Part 4 — Racial and ethnic identity (optional) *You are not required to complete this part.*

Ethnicity (Check one):

- Hispanic/ Latino
 Not Hispanic/Latino

Race (Check one or more):

- Asian
 White
 Black or African American

- American Indian or Alaska Native
 Native Hawaiian or other Pacific Islander

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 your child 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 last four digits of 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 or other FDPIR identifier for your child 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 your child is eligible for free or reduced-price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

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.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or
2. fax: (833) 256-1665 or (202) 690-7442; or
3. email: program.intake@usda.gov

This institution is an equal opportunity provider.



For information on the CACFP, visit the Connecticut State Department of Education's (CSDE) [CACFP website](#) or contact the [CACFP staff](#) at the CSDE, Bureau of Child Nutrition Programs, 450 Columbus Boulevard, Suite 504, Hartford, CT 06103-1841. This form is available at https://portal.ct.gov/-/media/SDE/Nutrition/CACFP/Forms/IncElig/Income_Eligibility_Application_CACFP_Homes.pdf

For sponsor use only – Do not write below this line

Annual income conversion: Weekly X 52 • Every 2 weeks X 26 • Twice a month X 24 • Monthly X 12

Total family income: \$ _____ Family size: _____ OR SNAP/TFA household Foster child

Eligible as Tier I Not eligible as Tier I

Sponsor eligibility official: _____ Date: _____

Signature