

## Child and Adult Care Food Program Income Eligibility Form

**Provider:**

**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: \_\_\_\_\_

