



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 eligibility number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**
 NAME: _____ ELIGIBILITY 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 *List of Eligible Federal/State Funded Programs (H1660)*, provide the name of the program and eligibility number: NAME: _____ ELIGIBILITY NUMBER: _____
 Check here if no eligibility number

Part 4. Total Household Gross Income—You must tell us how much and how often

| A. Name (List only household members with income) <i>(Example)</i> <i>Jane Smith</i> | 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 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: _____
 Last four digits of Social Security Number: * * * * - * * * - _____ I do not have a Social Security Number