

Rising Phoenix Enrichment Program, Inc.
INCOME ELIGIBILITY STATEMENT FORM CHILD AND ADULT CARE FOOD PROGRAM

Day Care Center's Name: _____ **F R P (circle one)**

PART I: Child or Adult enrolled to receive day care-						
Name: (Last, First and Middle Initial)			DOB	Food Stamp, TANF, or FDIPIR case number, Assistant Unit (AU), or Client ID number for <u>children only</u> . All the above, or SSI or Medicaid case number for Adults. Note: Do not use EBT numbers.	Head Start Participant	Foster Child
Last Name	First Name	Initial	NINE (9) DIGIT NUMBER ONLY			
					<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 III A:	B. Gross income and how often it is received				C. Check if NO Income
A. Name (List everyone in household, including foster and non-foster children)	Example: \$100/monthly, \$100/twice a month, \$100/every other week, \$100/weekly				
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Social Security, pensions, retirement	4. All other income	
1.	\$ ____ / ____	\$ ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
2.	\$ ____ / ____	\$ ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
3.	\$ ____ / ____	\$ ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
4.	\$ ____ / ____	\$ ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
5.	\$ ____ / ____	\$ ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
6.	\$ ____ / ____	\$ ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
7.	\$ ____ / ____	\$ ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
					<input type="checkbox"/>

PART III-B: ENROLLMENT INFORMATION: Children Only:

My child is normally in attendance at the facility between the hours of _____ [am/pm] to _____ [am/pm] on the following days: Check here if only before/after school care is provided.

(Circle/Check all that apply). Sunday Monday Tuesday Wednesday Thursday Friday Saturday

My child will normally receive the following meals while in care:
 (Circle/Check all that apply): Breakfast AM Snack Lunch PM Snack Supper Evening Snack

PART IV: Signature and Social Security Number (Adult must sign).

An adult household member must sign this form. If Part III is completed the adult signing the form must also list his or her Social Security number or mark the "I don't have a Social Security Number" box. (See Privacy Act Statement on 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 purposefully give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted. **This Signature also acknowledges that the child(ren) listed on the form in Part 1 are enrolled for care.***

Signature: X	Print Name	Date
Address:	City	State: GA Zip
Last four Digits of Social Security Number XXX-XX <input type="checkbox"/> I do not have a Social Security Number		

PART V: Participant's ethnic and racial identities (optional)

Mark one ethnic identity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	Mark one or more racial identities: <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or other Pacific Islander
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Official Use Only: Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12

Total Income: _____ Per Week Every 2 weeks Twice a Month Month Year Household Size: _____

Categorical Eligibility: _____ Date withdrawn _____ Eligibility: Free Reduced Paid Tier I Tier II

Temporary: Free _____ Reduced _____ Time Period: _____ (expires after _____ days)

Determining Official's Signature: _____ Date _____

Confirming Official's Signature: _____ Date _____

Follow Up Official's Signature: _____ Date _____

The participant in the day care facility may
Qualify for free and reduced price meals if
Your household income falls within the limits
On this chart.

Household Size	Yearly Income
1	13,520
2	18,200
3	22,880
4	27,560
5	32,240
6	36,920
7	41,600
8	46,280
Each Additional person	Add: 4,680

Privacy Act Statement: 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 social security of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Food Stamp, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child or other (FDPIR) identifier 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 Program.

Non-discrimination Statement: In accordance with Federal Law and I.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write to USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer falls within the limits on this chart.

INSTRUCTIONS

Households that receive Food Stamps, TANF, FDPIR, SSI or Medicaid: Complete the following:

Part I: For family day care home and child care center, list participant's name and a Food Stamp, TANF or FDPIR case number. For adult day care, list participant's name and a Food Stamp TANF, FDPIR, SSI or Medicaid case number. **Part II:** Skip this part.

Part III-A: Skip this part.

Part III-B: Child care centers only. Provide the normal days and hours your child is in attendance in the center and indicate the meals he/she normally receives while in care.

Part IV: Sign the form. A Social Security Number is not necessary.

Part V: Answer this question if you choose to.

If you are applying on behalf of a Foster Child, complete a separate application for each foster child and complete the following:

Part I: For family day care home and child care center, list participant's name and a Food Stamp, TANF, or FDPIR case number. For adult day care, list participant's name and a Food Stamp TANF, FDPIR, SSI or Medicaid case number. **Part II:** Please contact us [phone number].

Part III-A: Skip this part.

Part III-B: Child care centers only. Provide the normal days and hours your child is in attendance in the center and indicate the meals he/she normally receives while in care.

Part IV: Sign the form. A Social Security Number is not necessary.

Part V: Answer this question if you choose to.

All other Households, including WIC households, complete the following:

Part I: For family day care home and child care center, list participant's name and a Food Stamp, TANF, or FDPIR case number. For adult day care, list participant's name and a Food Stamp, TANF, FDPIR, SSI or Medicaid case number. **Part II:** Skip this part.

Part III-A: To report total household income from last month, complete the following:

Column A-Name: List the first and last name of each person living in your household as an economic unit. You must indicate yourself and all children living with you. In the case of an adult participant, the adult participant, and if residing with the adult participant, the spouse and dependent(s) of the adult participant. Attach another sheet if necessary. **Column B-Gross Income last month and how often it was received:** Next to each person's name, list each type of income received last month, and how often it was received.

Box 1: List the gross income each person earned from work. This is not the same as take-home pay. Gross income is the amount earned before taxes and other deductions. The amount should be listed on your pay stub, or your boss can tell you. Next to the amount, write how often the person got it (weekly, every other week, twice a month, or monthly). **Box 2:** List the amount each person got last month from welfare, child support, alimony.

Box 3: List Social Security, pensions, and retirement.

Box 4: List all other income sources including Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits IVA benefits), disability benefits, regular contributions from people who do not live in your household. Report net income from self-owned business, farm, or rental income. Next to the amount, write how often the person got it. If you are in the Military Housing Privatization Initiative do not include this housing allowance.

Column C-Check if no income: If the person does not have any income, check the box.

Part III-B: Child care centers only. Provide the normal days and hours your child is in attendance in the center and indicate the meals he/she normally receives while in care.

Part IV: An adult household member must sign the form, and list his/her social security number. Or, mark the box if he/she does not have one.

Part V: Answer this question if you choose to.

Privacy Act Statement: This explains how we use the information you give us.

SHARING INFORMATION WITH MEDICAID/SCHIP

Dear Parent/Guardian:

If your children qualify for free or reduced price meals, they may also be able to get free or low cost health insurance through Medicaid or the State Children's Health Insurance Program (SCHIP). Children with health insurance are more likely to get regular health care and are less likely to become sick.

Because health insurance is so important to children's well-being, the law allows us to tell Medicaid and SCHIP that your children are eligible for free or reduced priced meals, *unless you tell us not to*. Medicaid and SCHIP only use the information to identify children who may be eligible for their programs. Program officials may contact you to offer to enroll your children in this health insurance program. Filling out the CACFP Meal Benefit Income eligibility Forms does not automatically enroll your children in health insurance.

If you do not want us to share your information with Medicaid or SCHIP, fill out the form below and send it with your income Eligibility Form to Youth Educational Service, Inc. by the end of the (date) month. (Sending in this form will not change whether your children get free or reduced price meals).

No! **IDO NOT** want information from my CACFP Meal Benefit Income Eligibility Form shared with Medicaid or the State Children's Health Insurance Program.

If you checked no, fill out the form below.

Name of Day Care Center: _____

Child's Name: _____

Child's Name: _____

Child's Name: _____

Child's Name: _____

Signature of Parent/Guardian: _____

Today's Date: _____

Print Your Name: _____

Address: _____

For more information, you may call **Rising Phoenix Enrichment Program, Inc.** at **(678) 289-8356**

October 2008

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