

MEAL BENEFIT APPLICATION

For Child and Adult Care Food Program (CACFP)

July 1,2009-June 30, 2010

Provider's Own: Y ___ N ___

Provider #

Provider Name

Address

City, State, Zip

PART 1 - CHILD(REN)'S INFORMATION (If needed, you may attach an additional piece of paper to add more children.)

Last Name First Name Date of Birth Child #

1A. ENROLLED CHILD (CHILDREN) INFORMATION/CATEGORICAL ELIGIBILITY: Parents or guardians complete

If a child is enrolled in any of the following programs, provide the applicable case number or check the appropriate box. If a program or case number is listed for all children, proceed to Part 4. Do not complete Part 3.

Last Name	First Name	Food Supplement Program (FSP - formerly known as the Food Stamp Program) #	TCA# ¹	Head Start ²	School Meals ³	WIC ⁴	Even Start ⁵	POC ⁶

If a FSP or TCA# is provided for all enrolled children listed, you may proceed to Part 4; a Social Security Number is not required.

¹ Attach documentation from a Head Start authority to demonstrate child enrollment in Head Start

³ Free and reduced-price recipients of the National School Lunch Program and School Breakfast Program.

⁴ Special Supplemental Nutrition Program for Women Infants and Children (WIC).

⁵ Pre-Kindergarten participants of the Even Start Program.

⁶ Purchase of Care,

PART IB. CHILD CARE PROVIDER INFORMATION (To be completed by the child care provider, if applicable)¹ If a FSP or TCA# is provided you may proceed to Part 4; a Social Security Number is not required.

Last Name	First Name	FSP#	TCA #

PART 2 - FOSTER CHILD: Check if the child is the legal responsibility of the department of social services or court. Write the child's personal use monthly income: \$ _____. The foster parent/official representing the child must sign the application in part 4. A Social Security Number is not required. Complete one form for each foster child in your household.

PART 3 - TOTAL HOUSEHOLD GROSS INCOME - If Part 1A was not complete for each child, or if Part IB or 2 were not applicable, please complete Part 3. You must tell how much and how often (i.e., weekly, every other week, twice a month, or monthly). Example; \$200/weekly.

Names of All Household Members (Include the child (children) named above.)	EARNINGS FROM WORK (before deductions)		ADDITIONAL INCOME (Child Support, Alimony, TCA, Pensions, Retirement, Social Security Income)		ALL OTHER INCOME		Check if NO income
	Income		Income		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"/>

PART 4 - SIGNATURE AND SOCIAL SECURITY NUMBER

I certify that all of the above information is true and that all income is reported. I understand that this information is being given for the provider's receipt of federal funds and that if I purposely give false information, I may be prosecuted.

Signature of Adult Household Member _____ Date _____
 Print Name: _____ Social Security Number* Telephone No. (H) _____ (W) _____
 Address: _____ City: _____ State: _____
 ZIP: _____

PART 5 - CHILDREN'S ETHNIC AND RACIAL IDENTITIES (Optional)

Choose One Ethnicity	Choose one or more (regardless of ethnicity)
CD Hispanic or Latino	<input type="checkbox"/> I Asian <input type="checkbox"/> American Indian/Alaskan Native
<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> White <input type="checkbox"/> Black/African American <input checked="" type="checkbox"/> Native Hawaiian/Other Pacific Islander

*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, it may reduce the amount of reimbursement the provider may be entitled to. The adult household member signing the application must include their Social Security Number unless: they do not have a Social Security Number; the application is for a foster child; or a FSP or Temporary Cash Assistance case number has been provided for the child (children). We will use your information to determine the provider's Program reimbursement and for administration and enforcement of the meal programs. Program reviews and investigations may be conducted to verify correctness of any information provided on this form or to look into violations of program rules. These efforts may include contacting employers and State or local governmental offices. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs.

FOR SPONSOR USE ONLY Annual Income Conversion: Weekly X 52, Every 2 Weeks X 26, Twice a Month X 24, Monthly X 12

Providers Home or Own Child				Enrolled Child			
FSP Household: Q Yes	Q No	TCA: Q Yes	G No	FSP Household: Q Yes	Q No	TCA: Q Yes	Q No
Household Size:	Total Income:	Per:		Household Size:	Total Income:	Per:	
Q Week Q Every 2 Weeks 0 Twice a Month U Monthly Q Yearly				Q Week Q Every 2 Weeks Q Twice a Month U Monthly G Yearly			
Eligible by Income: Q Yes	Q No			Eligible by Income: Q Yes	Q No		
If "Yes," has the income verification been completed? U Yes	Q No			Categorically Eligible: Q Yes	Q No		
(Attach documentation.)							
Determining Official's Signature/Date Signed				Determining Officials Signature/Date Signed			